asisp
Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

Croatia

March 2012

Author: Nada Bodiroga-Vukobrat

Disclaimer: This report reflects the views of its authors and these are not necessarily those of either the European Commission or the Member States.

On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
GVG

Table of Contents

1 Executive Summary

The reporting period in Croatia is marked by persevering financial and economic crisis, change of government and the successful closure of the negotiation process for accession to the EU. All of these occurrences will shape social protection policies and the reform dynamics in the upcoming periods as well. More than one-half of Croatian households have been affected adversely by the crisis.[1] The main task of the new government is to reinvigorate the economy and competitiveness, within a limited or no manoeuvring space determined by strict fiscal consolidation. The main challenge is to increase employment, given that the registered unemployment rate peaked in January at 19.8%.

The financing of the pension system is imbalanced. It is estimated that pension contributions cover only 58% of the total pension expenditures and 80% of contributory pensions, whereas the remaining difference is covered from budget transfers. The dependency ratio (at 1:1.21) and net replacement rate (at 37.55%) reached an all-times low in December 2011. The origins of this problem lie in the system's structural weaknesses. The economic and financial crisis is an aggravating factor and not the cause of this instability. However, the severe impact of the crisis, primarily in the economic sector and labour market, will certainly shape and complicate all future actions to remedy the system's failures. Future reforms should address the outstanding issues of retirement age (increasing it or linking to life expectancy), levelling cross-cohort and cross-pillar differences among pensioners, reviewing the role of minimum pensions and criteria for disability pensions, strengthening the link between contributions and pensions, reviewing the administrative costs of pension institutions and establishing appropriate framework for social pensions.

The new Government's plans for refurbishment of the health care system announce a shift towards patient-oriented health policy and include reorganisation of emergency medical care, primary health care and hospital management, education of human resources, reduction of waiting lists and promotion of prevention. Although the budget of the Ministry of Health in 2012 will be cut by HRK 600[2] million, it should not affect the level and scope of benefits in the health basket. The total deficit of health care system amounts to HRK 5.2 billion, with hospitals as the major debt generators. Sustainability of the system in the future period will mainly depend on ensuring more efficient administration of hospitals. Reform of emergency health care with the aim of remedying the past mistakes, ensuring better accessibility and quality of services is also one of the key priorities in the next period. It remains to be seen whether the latest reforms would be based on more elaborated strategies and follow a bottom-up approach, i.e. pay due regard to the opinion and experiences of medical professionals.

In 2011, the social welfare reform legislative package finally entered into force. Long-term care arrangements are still based on the already existing, but slightly modified benefits in cash and in kind. There is no integrated approach to long-term care issues and those in need of it are perceived either as a health care or as a social welfare problem. The role of the family in planning long-term care policies should not be neglected. More flexible arrangements for family members who take care of their relatives (i.e. financial relief or flexible working hours) should at least be taken into consideration. The emphasis in the current system is instead placed on private providers of deinstitutionalised social services. However, they should be more closely and regularly monitored to assure observance of high quality standards. Additional institutional capacities are needed to cover the rising needs for stationary and palliative care.

---

1 European Bank for Reconstruction and Development (2011), Life in Transition Survey II, retrieved on 05.02.2012 at http://www.ebrd.com/pages/research/publications/special/transitionII.shtml.

2 Average exchange rate in February 2012 is EUR 1.00 = HRK 7.5818; InforEuro: http://ec.europa.eu/budget/contracts_grants/info_contracts/inforeuro/inforeuro_en.cfm.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Two main events that will affect the development of the social protection policies in the upcoming phase took place near the end of the reporting period. The first one is the signing of the Accession Agreement of the Republic of Croatia to the EU on 9 December 2011 with subsequent positive vote by the Croatian citizens in the referendum for joining the EU on 22 January 2012. Although Croatia is becoming an EU member in times of the persevering global financial crisis and economic stagnation, benefits of membership will hopefully reflect in its social protection policies as well. The second event is the general elections for the Croatian Parliament. Since the latter event marks a shift in governance and a reorientation of policies in general, it deserves a detailed exposure before turning to specific aspects of social protection systems developments.

On 4 December 2011, the general elections for the members in the Croatian Parliament (*Croatian*: Sabor) were held. The right-centre Croatian Democratic Union (HDZ), which was the ruling party since the 1990s (except in the period from 2000 to 2003), was overthrown by the opposition *Kukuriku* coalition of four parties: leading and the largest among them the left-centre Social Democratic Party (SDP), liberal Croatian Peoples Party (HNS), regional Istrian Democratic Congress (IDS) and the Croatian Pensioners Party (HSU). With the election response of approximately 62% of the voters, the coalition won 80 seats in the Parliament, which enabled it to form a steady government, while HDZ won 47 seats with its partners. The new Croatian Labour Party (Hrvatski laburisti) surprisingly won 6 seats alone and thus became the third largest party in the Parliament. In the new government with 21 members, led by the Prime Minister Zoran Milanović, some ministries were reorganised and their field of competences reassigned.

With effect from 22 December 2011, the new division of competences and reorganisation of ministries and other central state authorities took place. As part of the state administration reform, the new division should guarantee more efficient performance of state prerogatives to serve the needs of its citisens. The pension system administration was given a more prominent position with the dissolution of the massive Ministry of Economy, Labour and Entrepreneurship into the Ministry of Economy, the Ministry of Entrepreneurship and the Ministry of Labour and Pension System. The old Ministry of Health and Social Welfare is now solely the Ministry of Health, because its previous social welfare component was separated and transferred, together with some of the functions of the old Ministry of Family, War Veterans and Inter-Generational Solidarity, to the new Ministry of Social Policy and Youth. The Croatian name of the Ministry of Health was changed (from Ministarstvo *zdravstva* to Ministarstvo *zdravlja*, which was criticised by linguists as not appropriate, since the former connotes the health care system, while the latter refers only to the state of being healthy). Some of the first public statements by the new ministers charged for various aspects of social protection signal the impending reorganisation of the system and its institutions, which should not affect the existing level of social protection and benefits. The Minister of Social Policy and Youth Ms Milanka Opačić thus announced the amendments to the Social Welfare Act (which came into force only 6 months ago, in June 2011) and restoration of the old social welfare system; while the Minister of Health Mr Rajko Ostojić's main priorities will be the waiting lists and dealing with what he calls "the private monopolies" in health care provision.[3] The Minister

[3] Newspaper article, Jutarnji list, 24/25/26.12.2012.

of Labour and Pension System Mr Mirando Mrsić has announced the reorganisation of the Croatian Pension Insurance Fund, with strengthened supervision of its work, the downsising of employees (currently around 3,000) and transferring of the Fund's portfolio shares to the Ministry of Finances.[4]

The change of government brought about a shift in the economic and financial policy, with the announced tax reform (introduction of new and increase of the existing taxes, with simultaneous reduction of quasi-fiscal payments in the economic sector) and fiscal consolidation (reduction of budgetary expenses, rationalisation of employment in the public sector). The highest government officials claim that the anticipated reforms should not, however, have a negative impact on the social protection and fairness and are based on a just redistribution of social weight.[5] On 26 January 2012, the Government represented the Guidelines for the drafting of the new State Budget for 2012,[6] aimed at preserving the credit rating of the country and confidence of the financial markets, with the projected reduction of budget deficit of HRK 4.6 billion. However, the final budget proposal, presented on 13 February 2012, is less ambitious and cuts the costs for only HRK 3.4 billion, i.e. the budget deficit is estimated to amount to HRK 9.9 billion.[7] The Government's macroeconomic projections of 0.8% economic growth already in 2012 and accelerated growth of real GDP in 2013 and 2014 of 1.5% and 2.5% respectively depend on the full realisation of the investment potential and the absence of negative external trends. Export of goods and services and investments are supposed to be the drivers of economic growth in the upcoming period. Fiscal consolidation on the revenue side of the budget should not affect the overall tax load. Nevertheless, significant changes are foreseen for various types of taxes in an attempt to increase competitiveness through lower taxation of labour costs, but higher taxation of consumption and creation of preconditions for future higher taxation of income. The tax reform is claimed to be socially sensitive, i.e. pay due regard to the social position of the taxpayers. Basic personal deduction should rise from HRK 1,800 to HRK 2,500 and tax classes for payment of income tax are going to change, but the tax rates will stay at 15, 25 and 40%. The Value Added Tax (VAT) rate will, on the other hand, rise for additional 2% (from currently 23% to 25%), with some concessions (lower VAT rate of 10% is foreseen for a certain number of basic supplies, such as oil and fats (?!), baby food and water supply). The rate of contribution for obligatory health insurance should decrease from 15% to 13%. On the costs side of the budget, the planned savings of HRK 3.4 billion are already criticised as too low to be able to cover the rising budget deficit (in 2011, estimated at HRK 16.2 to 20 billion). Consequently, the savings of at least 5 to 9 billion HRK should be planned.[8] The expected outcomes on the citizens' standard of living due to the rise of the VAT rate and the consequential rise of consumer goods prices (estimated for the maximum of 1.4%) should be offset by the differentiated VAT rate for certain products, increase of the non-taxable part of the income (personal tax deduction; for example the lowest salary, which is received by 750,000 employees, is expected to rise for HRK 70 – 80 or 1.5 to 2%), reinstatement of the pension indexing and the growth of employment (as a result of lower labour costs and ALMP measures). The primary reproach is, however, that the guidelines are too general and lack

4 Vjesnik.hr, 11.01.2012.
5 Minister of Regional Development and EU Funds Mr Branko Grčić, Novi list 19.12.2011.
6 Government of the Republic of Croatia (2012), Prijedlog mjera i smjernice za izradu proračuna za 2012. godinu, retrieved on 27.01.2012 at http://www.vlada.hr/hr/aktualne_teme_i_projekti/aktualne_teme/proracun_2012.
7 The deadline for the adoption of the new budget is 1 April, with the temporary financing in force until its adoption. The extension of the deadline for this year's budget is due to the parliamentary elections and the change of government at the end of 2011.
8 Newspaper article, Novi list, 11.01.2012.

verifiable data to asses how the planned goals are to be achieved.[9] The final budget proposal is currently debated in the Parliament, but many economic experts believe its first rebalance will ensue in three to four months after its adoption.[10]

The Government projections of growth contradict economic forecasts from various international and domestic institutions, which warn that external factors, such as the uncertainties in the Euro area, international banking system and financial markets represent the major downside risk to growth and the Croatian economy will likely enter into another recession in 2012.[11] The Institute of Economics projects a decline of real GDP of -0.3% in 2012, with a mild recovery estimated at 1% in 2013.[12] The recent IMF Staff Visit to Croatia (February 2012) projected a GDP decline of about 1% in 2012, reflecting continued weakness of domestic demand due to corporate deleveraging and household debt overhang.[13] However, these projections did not include the latest announcements of public investment projects, as their impact was unclear at the time of the analysis. The key message is that if policies remain unchanged and without fiscal consolidation to ensure sustainable debt dynamics, economic prospects are weak. The 2012 Fiscal Guidelines are, according to the IMF, a step in the right direction. Nevertheless, the IMF suggests that wage reductions, reducing public sector employment and increasing labour market flexibility by changing labour laws to induce more competitive wage setting and to reduce hiring and firing costs should be part of the structural reforms needed to increase competitiveness of the labour market, which is one of the most uncompetitive in the region. Low labour force participation is seen as a result of the generous social benefits system.[14] Ambiguous messages regarding the labour market reforms are coming from the Government. PM Milanović, somewhat inadvertently, claims that the Government has no intention of proposing further amendments to the Labour Act (apart from renegotiation of the automatic renewal clause in collective agreements, which will probably be fiercely opposed by the unions, as it will entail a termination of certain rights granted in them), nor of dismissing employees from public services.[15] His ministers, on the other hand, admit that reduction of employees, whether by dismissal, natural outflow or in any other manner in the public sector is a necessity. Employers' associations, investors and analysts warn that the rigid labour regulations are the main obstacle for growth and competitiveness and need to be changed.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The comprehensive reform of the pension system in Croatia started in 1998, with the introduction of a three-pillar system. The pension insurance covers the risks of old age, death and disability of the insured. The general pension insurance scheme is regulated by the Pension

[9] For a criticism, see Ott, Katarina (2012), Smisao i svrha smjernica makroekonomske politike, Aktualni osvrt br. 34, 01.02.2012, Institute of Public Finances, retrieved on 05.02.2012 at http://www.ijf.hr/upload/files/file/osvrti /34.pdf.

[10] Newspaper article, Jutarnji list, 14.02.2012.

[11] See, for example, The World Bank (2011) EU 10+1 Regular Economic Report, Croatia Supplement, retrieved on 10.01.2012 at http://siteresources.worldbank.org/ECAEXT/Resources/258598-1256755672295/6517642-1321421981603/EU10RER_CroatiaDec2011.pdf.

[12] The Institute of Economics, Zagreb (2012), Croatian Economic Outlook Quarterly No. 49/January 2012.

[13] The International Monetary Fund, Croatia: Concluding Statement of IMF Staff Visit, 03.02.2012, retrieved on 07.02.2012 at: http://www.imf.org/external/np/ms/2012/020312.htm.

[14] Ibid.

[15] PM Milanović at the meeting with the representatives of 5 trade unions, 01.02.2012; retrieved on 02.02.2012 at http://www.vlada.hr/hr/naslovnica/novosti_i_najave/2012/veljaca/vlada_nece_mijenjati_zor_ni_otpustati_javne_sluzbenike.

Insurance Act,[16] the Act on Compulsory and Voluntary Pension Funds,[17] and the Act on Pension Insurance Companies and Pension Payments based on the Individual Capitalised Savings.[18]

The pension system is based on three insurance pillars:

1. Compulsory pension insurance based on generational solidarity – "PAYG" (pillar I)

2. Compulsory pension insurance based on individual savings (pillar II)

3. Voluntary pension insurance based on individual savings (pillar III).

As of 1 January 2002, all employed persons are placed into three categories within the new pension system:

a) Compulsory multi-pillar (first and second pillar) participants: Employees under the age of 40 at the time of the reform;

b) Optional multi-pillar (first and second pillar) participants: Employees in the age group between 40 and 50 at the time of the reforms, who were given the option to be insured only within the system of generational solidarity (first pillar), or in both pillars (first and second) (in that case they would have the same status as the category described under point a). The choice of the system was permanent and could not be changed until legislative amendments in 2011 relaxed this regime.

c) Compulsory first pillar participants: employees above the age of 50 at the time of the reform.

All employees, regardless of their age, can be included in the voluntary pension insurance system based on individual savings (pillar III).

Pensions under general provisions comprise old-age pensions (including early pensions), disability pensions and survivors' pensions. Apart from the beneficiaries who are entitled to pension under general provisions, there are (now) 12 categories of so-called 'privileged pensioners', who stand to receive pension under privileged conditions based on their status.[19] The largest category is the war veterans from the Homeland War.[20] One of the promises of the governing coalition during the electoral campaign was fulfilled already at the beginning of their mandate. With effect from 6 February 2012, privileged retirement conditions for members of the Parliament (a constant source of public discontent due to unproportionally high pension amounts) were abolished.

Mixed *financing* (public and private) is evident through the pillar structure. The contribution rates are prescribed under the Act on Contributions[21] and the Ordinance on Contributions.[22] The rate of contribution for the insured persons within the first pillar (based on generational solidarity) is 20%. The rate of contribution for the insured persons both within the first and the

[16] Official Gazette of the Republic of Croatia, *Narodne novine* no.102/98, 127/00, 59/01, 109/01, 147/02, 30/04, 117/04, 92/05, 79/07, 35/08, 121/10, 130/10 – consolidated version, 61/11 and 114/11.

[17] Official Gazette of the Republic of Croatia, *Narodne novine* no. 49/99, 63/00, 103/03, 177/04, 71/07, 124/10 and 114/11.

[18] Official Gazette of the Republic of Croatia, *Narodne novine* no. 106/99, 63/00, 107/07 and 114/11.

[19] There was a total of 177,205 privileged pensioners in December 2010, which is approximately 15% of the overall number of pensioners (1,023,181), with HRK 7.2 billion or 20% of all pension expenditures in 2010 designated (in the state budget) for their payment.

[20] 1.5% of GDP in 2010 was distributed for Homeland War Veterans, which makes it the largest privileged pension programme (out of over 2% of GDP designated for all privileged pensions). The World Bank (2011) Croatia: Policy Options for Further Pension System Reform, retrieved on 10.01.2012 at http://siteresources.worldbank.org/INTCROATIA /Resources/Croatia_ Policy_Notes-Pension.pdf.

[21] Official Gazette of the Republic of Croatia, *Narodne novine* no. 84/08, 152/08 and 94/09.

[22] Official Gazette of the Republic of Croatia, *Narodne novine* no. 2/09, 9/09 and 97/09.

second pillar is split: 15% in the first pillar and 5% in the second pillar. The basis for calculation is the wage or other earnings (in case of employed persons) or income (in case of self-employed or other categories of insured persons). The contribution is paid up from the basis for calculation.

As of 1 November 2010, the *retirement age* for old age and early pension between men and women is gradually equalising, by raising the retirement age for women for 3 months each year. Full equalisation will be completed by 2030 (65 for old age pension and 60 for early retirement).

Early retirement is sanctioned with monthly deduction which varies in accordance with the accrued pension service; from 0.15% to 0.34% per month of early retirement (i.e. permanent decrement from 1.8% to a maximum of 4.08% per year, early retirement period is up to five years). On the other hand, the extension of the working life is financially stimulated with 0.15% increase of the amount of pension per month of later retirement, up to a maximum of five years, i.e. a maximum of 9% increase is possible.

The pension formula is the product of personal points (PP), variable pension factor according to the type of pension (PF; 1.00 in case of old-age, early retirement and disability pensions) and the actual pension value (APV): pension = PP x PF x APV. The actual pension value is the determined amount of pension for one personal point. Pension indexation in accordance with the so-called "Swiss formula" takes place every six months at the rate which represents 50% of the rate of fluctuation of the average consumer price index and 50% of the rate of fluctuation of the average gross salary of all employees in the Republic of Croatia in the preceding half-year period compared to the six months before that (i.e. 50% of the price increase and 50% of the wage increase).[23] Personal points are calculated in accordance with the prescribed formula and basically represent the worker's contribution to the pension fund with his/her benefit.

Personal allowance is preferential, i.e. higher than that of other categories of tax payers (currently HRK 3,200[24]). Taxation follows the pillar structure. One fifth of the pensioners are liable to pay income tax.[25]

In the reporting period, there were several changes in the pension system:

- abolition of the privileged retirement conditions for members of the Croatian Parliament, judges of the Constitutional Court and the General State Auditor[26];
- integration of the pension supplement received by the first pillar retirees who retired after the 1999 reform (in the amount from 4 to 27%) in the amount of pension[27];
- recalculation of pensions in accordance with the first pillar rules at the request of those retirees who opted to be included in both insurance pillars (those in the age group between

[23] Pension indexation was suspended in 2010 and 2011.

[24] The latest tax reforms envisage the increase of the personal allowance to HRK 3,400 (Draft Act on Amendments to the Income Act, retrieved on 10.02.2012 at http://www.vlada.hr/hr/naslovnica/sjednice_i_odluke_vlade_rh/2012/7_sjednica_vlade_republike_hrvatske.

[25] On the inequalities in the taxation of pensions see ZUBER, MARIJA (2011) Kontroverze važećeg sustava oporezivanja mirovina, retrieved on 24 April 2011 at: http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

[26] Act on Amendments to the Act on rights and duties of the Member of the Croatian Parliament, Official Gazette of the Republic of Croatia, *Narodne novine* no. 55/00, 107/01, 86/09, 91/10, 49/11 and 12/12.

[27] Act on Amendments to the Pension Insurance Act and Act on Amendments to the Act on Supplement to Pensions realized under the Pension Insurance Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 114/11.

40 and 50 in 2002) and the possibility to abandon the second pillar for still employed insurees who belong to the same category[28].

Of all the categories of privileged pensioners, the one receiving the highest pension amounts upon retirement were the members of the Parliament.[29] Their amount of pension was disproportionate to the service time. Prior to the amendment, only one mandate (4 years or less) in the Parliament triggered the special circumstances for retirement. Although the abolition of this privilege and unification with the general pension system was (rightly) greeted with public approval, as its social sensitivity in times of crisis is undeniable, projection of its financial benefits for the system is not provided. Furthermore, not all public officials are caught by the measure: it applies to the judges of the Constitutional Court and the General State Auditor, but not to the President of the State.

Pension supplement of 4-27% on pensions realised after the pension reform (i.e. in 1999 and later) was introduced in 2007 to mitigate considerable differences in the amount of those pensions in comparison with the pensions realised prior to the reform. Only retirees who receive pensions solely from the first pillar were entitled to the supplement, which was paid from the State budget and not subject to taxation. In July 2011, there were approximately 300,000 of such beneficiaries, with the average supplement in the amount of HRK 351 (approximately EUR 50).[30] With effect from 1 January 2012, the supplement was integrated in the amount of pension. The aim of equalising the regime for pensions and supplements is to enhance the pensioner's position and alleviate differences between these different categories of pensioners. However, the position of multi-pillar retirees is unchanged, as they are still left out from this entitlement. Many experts fear that this could produce substantial abandoning of the second pillar,[31] as the first gateway is now opened with the entering into force of the legislative amendments in 2011 (as explained hereunder). Furthermore, by bringing the supplement under the same legal regime as pensions, the burden for their financing shifts to the first pillar revenues framework, which is already insufficient to cover the costs.

One of the most important changes in the pension system in the reporting period was the possibility to transfer from the second to the first pillar for optional multi-pillar participants and pensioners (employees in the age group 40-50 in 2002). The opening of this gateway was justified with the need to improve the material and social status of such pensioners, whose pension was lower by HRK 300 to 1,500 than the pension of pensioners under the first pillar. This substantial difference resulted from the fact that they were not entitled to pension supplement (as explained above), but also due to the fact that the majority of such pensioners are women who retired early from mostly low paid jobs and who paid contributions to the second pillar for a very short time. Their average retirement age was 55-57 years, whereas the expected lifetime upon retirement is 30 years. As a result, the average amount of pension acquired from the second pillar was extremely low: HRK 107.17 (in addition to the average

[28] Act on Amendments to the Pension Insurance Companies and Pension Payment based on Individual Capitalised Savings and Act on Amendments to the Act on Compulsory and Voluntary Pension Funds, Official Gazette of the Republic of Croatia, *Narodne novine* no. 114/11.

[29] According to the Statement of Reasons accompanying the Act on Amendments to the Act on rights and duties of the Member of the Croatian Parliament parliamentary pension amounted on average almost four average pensions received under general conditions (in September 2011, the average pension was HRK 2,364.77, while the parliamentary pension was HRK 8,906.06), which is not only disproportionate to other pensions, but also to the general economic and social circumstances in the country.

[30] Statement of reasons accompanying the Draft of the Act on Amendments to the Pension Insurance Act (Official Gazette of the Republic of Croatia, *Narodne novine* no. 114/11).

[31] See, for example, Zoran Anušić, Senior Economist at the World Bank, in an interview to newspaper Jutarnji list, 13.11.2011.

amount of pension from the first pillar of HRK 1,965.83[32]). At the time the amendments were proposed (September 2011), it was estimated that there were already around 1,200 of such pensioners and most of them requested the recalculation of pensions within the prescribed deadline. However, the possibility to revert their choice made in 2002 and go back to the first pillar was given also to current members of the compulsory pension funds (i.e. those who are still employed) if they belong to the same category of insurees (i.e. those between 40-50 years in 2002 who opted for insurance under both pillars). They can exercise this right when they decide to retire. The majority of 95,000 persons eligible for such transfer will thus probably decide to abandon the second and 'return' to the first pillar as a more favourable option at the time of retirement, i.e. until 2027 at the latest. This certainly presents a great strain for public finances in the long term and, as rightly pointed by experts, creates unjustified distrust in the second pillar as the cause of lower pensions.[33] Staying in the second pillar will be a more favourable option only for a limited number of beneficiaries who are not entitled to supplement or the supplement is lower than the amount of pension from the second pillar or for those who receive survivors' pension from the first pillar, while retaining the right to payment of their personal pension from the second pillar.

2.2.2 Debates and political discourse

The Government Programme for the mandate 2011-2015[34] acknowledges that a structural reform in health, pension and social sector is needed to stabilise public finances in a long-term. Guided by the principle "security in old-age for everyone", the Government pledges to continue the pension reform by opening up a public debate. Three main directions of reform will concern new pensioners (developing sustainable and fair system for realisation of pension rights), old pensioners (ensuring sustainable pension adjustment system and optimal realisation of pensions from the first pillar) and different categories of pensioners (setting clearer standards for general and preferential systems). However, the dynamics of all of the activities will depend on the economic and employment growth. The existing level of pensions will not be reduced. Although a review of some of the important system parameters, notably the retirement age is announced, explicit reference to the question of increasing the retirement age or linking it to life expectancy is lacking. It is to be concluded that this is still a highly sensitive political issue, which no government is ready to touch upon (yet). Moreover, despite the proclaimed promotion of full service time for both genders, just a few passages thereafter, the Programme introduces the possibility of a more flexible framework for retirement of women 'who bear special workload' (whatever this formulation may imply). The establishment of the "zero" pillar as a platform for payment of basic, tax-financed support for beneficiaries either on a universal basis or linked to the means-assets test is announced. The obligation of the competent institution to notify insurees of the status of payment of contributions to their accounts will be prescribed.[35] Further proposed measures include the stimulation of longer stay in employment, as well as saving within the voluntary third pillar.

In 2011, the World Bank analysts have conducted and prepared a pension simulation model, in collaboration with the Croatian Pension Institute and the former Ministry of Economy, Labour and Entrepreneurship. The resulting document *Croatia: Policy Options for Further Pension*

[32] Data from December 2010, provided in the Statement of Reasons accompanying the Draft Act on Amendments to the Pension Insurance Companies and Pension Payment based on Individual Capitalised Savings (Official Gazette of the Republic of Croatia, *Narodne novine* no. 114/11).

[33] Štimac, Dubravko (2011), Obvezni mirovinski fondovi – prvih 10 godina, in: Zbornik radova Analiza mirovinskog sustava, Banka magazin i Institut za javne financije, Zagreb, retrieved on 11.01.2012 at http://www.bankamagazine.hr/LinkClick.aspx?fileticket=W6kzsdxFPSY%3d&tabid=43.

[34] The Government of the Republic of Croatia (2011), The Government Programme for the mandate 2011-2015, retrieved on 24.12.2011 at http://www.vlada.hr/hr/preuzimanja/program_vlade_2011_2015.

[35] Insufficiencies and information gaps in that segment were highlighted in the Croatian ANR 2011.

System Reform[36] assesses the impact of the already implemented measures and their combination with other potential measures which could enhance the system sustainability in the long run. The document identifies inflated first pillar expenditures (at 10.6% of GDP[37]), worsening demographic ratios, low labour participation rates, low and declining replacement rates, inadequate pensions for multi-pillar cohorts, large cross-cohort differences in pensions and overly generous special schemes as the main points of concern.

Rising pension expenditures are a major threat to the system's stability. It is estimated that pension contributions cover only 58% of total pension expenditures and 80% of contributory pensions, whereas the remaining difference is covered from budget transfers.[38] At the same time, there is no room for increasing the pension contribution rate, which is among the lowest in the region, given that other social insurance contributions are relatively high (particularly for health). To preserve the sustainability of the system, retirement age will have to be aligned with life expectancy. However, this unpopular measure is currently discussed only in professional circles. Policy and decision-makers are not working towards raising of the public awareness on this issue. The Eurobarometer Active Ageing Survey 2011 reveals that two thirds or 66% of respondents in Croatia totally disagree that the official retirement age will need to increase by the year 2030 (as opposed to 36% in the EU).[39] The World Bank projections show that given the current retirement age, the average old age replacement rate cannot rise above 40%.[40] The transition period for equalisation of the retirement age for women (by 2030) is too slow, since by that time, life expectancy is expected to rise by another two to three years. Early retirement decrements and late retirement incentives are criticised as to weak to stimulate longer stay in employment. The role of minimum pensions has to be reevaluated as well, since the high minimum pension and high replacement rates for low-wage earners stimulate evasion of contributions[41] (in 2009, 10% of contributors reported minimum wages). Cross-cohort pension differences are patched up with cyclically (and politically) awarded supplements, which created even larger discrepancies. The 2007 supplement, as explained above, was awarded only to first-pillar and not to optional multi-pillar pensioners who have also spend the greater part of their life paying into the first pillar. This difference will partly be alleviated by the latest legislative amendments, which enabled the switching of pillars and recalculation of a more favourable pension, but also brought additional burden to the financing of the system.

A valuable contribution to the public debate of the pension system issues has continued from the previous reporting period through the project *The Analysis of the Pension System*, managed by the Institute of Public Finances and the business magazine Banka. Various experts in the field of public finances, economy, taxation, social policy etc. have joined their forces in regular topical meetings in an effort to promote public awareness and understanding of the pressing issues. [42] These include 'standard' structural weaknesses, such as the role of minimum and

---

36 The World Bank, Croatia: Policy Options for Further Pension System Reform, cit. (FN 20). The World Bank simulations are based on the PROST model (World Bank Pension Reform Options Simulation Toolkit), used to analyse pension system features in more than 90 countries.

37 In comparison with 52 states included in the recent IMF study The Challenge of Public Pension Reform in Advanced and Emerging Economies (retrieved on 06.02.2012 at http://www.imf.org/external/np/pp/eng/2011/122811.pdf), only 7 countries report higher public spending for pensions than Croatia. See more in: Bađun, Marijana (2012), Izazov reformi javnog sustava mirovinskog osiguranja, Aktualni osvrt 35, Institut za javne financije, retrieved on 06.02.2012 at http://www.ijf.hr/upload/files/file/osvrti/35.pdf.

38 The World Bank, Croatia: Policy Options for Further Pension System Reform, cit. (FN 20).

39 Eurobarometer Survey on Active Ageing, Results for Croatia (2012), retrieved on 18.01.2012 at http://ec.europa.eu/public_opinion/archives/ebs/ebs_378_fact_hr_en.pdf.

40 The World Bank, Croatia: Policy Options for Further Pension System Reform, cit. (FN 20).

41 Vukorepa, Ivana (2011) Kapitalno financirani mirovinski sustavi kao čimbenici socijalne sigurnosti (PhD Thesis), Zagreb, p. 124.

42 Web site of the project: http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

disability pensions, labour participation of elderly, etc. Some of the topics in 2011[43] also included a critical evaluation of the administration costs of the institutions involved in the functioning of the first and second pillar (particularly the financial justification of the existence of REGOS – The Central Registry of Insured Persons, which spends 90% of its budget for outsourcing), investigation of the actual level of poverty among pensioners based on verifiable and comparable data and the level of financial literacy among pensioners.

An important study titled *Challenges and Possibilities for Realisation of Adequate Old-Age Pensions in Croatia* was published in 2011.[44] So far, it is the first comprehensive study of this subject, which combines the results of scientific research by experts from the Institute of Economics and Faculty of Law in Zagreb. It includes the analysis of the pension system development, projections of future pensions and suggested measures which should be implemented with the goal of realising adequate and sustainable pensions. The Study identifies demographic ageing of the Croatian population, unfavourable dependency ratio, relatively low actual retirement age and low employment rate as the main challenges of the Croatian pension system. Almost 40% of pensioners in Croatia are below 65 years of age, whereas the average duration of retirement is almost two third of average service time.[45] This is attributed to the fairly light conditions for early and disability retirement, as well as retirement under more privileged conditions. At the end of 2010, 22.9% of pensioners under the general system received disability pensions.[46] Around 28% of total pension expenditures was used for payment of disability pensions.[47] In 2010, Croatia had the lowest employment rate in comparison to all EU Member States, at 54.1% of active population (15-64).

Given that the net assets of compulsory pension funds have arisen to almost HRK 40 billion, the Government intends to define new, more relaxed rules for portfolio investment. The intention is to allow investment in projects of strategic importance for Croatia and concessions.[48] However, the success of this idea largely depends on the quality of its technical implementation, availability of profitable projects and careful consideration of all aspects in order to reach a sound investment decision.

All these discussions and analysis conclude that the financing of the system is imbalanced. The origins of this problem lie in the systems' structural weaknesses. The economic and financial crisis is an aggravating factor and not the cause of this instability. However, the severe impact of the crisis, primarily in the economic sector and labour market, will certainly shape and complicate all future actions to remedy the system's failures.

2.2.3 Impact of EU social policies on the national level

The majority of OMC objectives in the field of pensions are reflected in the Government Programme for the mandate 2011-2015, as elaborated in Section 2.2.2 of this ANR. The motto "Security in old-age for everyone" is supposed to stand for adequate retirement incomes in a financially stable and transparent pension system. The implementation of the OMC objectives in an economically unfavourable environment is extremely challenging. Solidarity within generations certainly plays a prominent role, although it sometimes yields the opposite effect of

[43] Round tables organized on 12.09.2011, 14.06.2011, 19.04.2011, 17.03.2011, 16.02.2011 and 19.01.2011.
[44] Nestić, Danijel (ed.) (2011) Izazovi i mogućnosti za ostvarenje primjerenih starosnih mirovina u Hrvatskoj, Ekonomski institut Zagreb, retrieved on 16.12.2011 at http://www.eizg.hr/Download.ashx?FileID=7d4509d2-866d-47b7-8214-a2cbf38ff8b9 .
[45] In 2010, it amounted to 18 years and 1 month.
[46] If privileged pensioners are included, this proportion rises to 27.2%.
[47] Nestić, op.cit., p. 19.
[48] Poslovni dnevnik, retrieved on 02.01.2012 at http://www.bankamagazine.hr/Naslovnica/Umre%c5%bei/tabid/320/View/Details/ItemID/74823/ttl/Drzava-izlazi-s-pravom-ponudom-pred-mirovince/Default.aspx.

creating inequalities among pensioners. As noted in the World Bank Report, the Croatian pension formula is highly redistributive between the lowest and the highest income cohorts. Thus, whereas the minimum wage earners might expect a net replacement rate of 100%, average wage earners stand to receive only 3% higher pension than the minimum pension.[49] It is to be concluded for some pensioners, living standard after retirement would deteriorate more than for others. A five-year early retirement window, among the highest in the region,[50] could also be seen as an expression of solidarity. The current and future interventions in the pension system will be concentrated on attaining financial sustainability while preserving the current pension benefits. Whether they are adequate to ensure a decent living in retirement is highly debatable.

Taking account of the Europe 2020 strategies for attaining smart, inclusive and sustainable growth in social, including pension policies can be tracked through the Joint Memorandum on Social Inclusion (JIM) Follow-up Process.[51] In May 2011, the Joint JIM/JAP Conference on the continuation of activities and implementation of measures was held in Zagreb.[52] Among other topics, the translation of the Europe 2020 objectives in the Croatian context was discussed, particularly regarding the pension reform and health protection. Croatian key priorities are to decrease the disproportion of the labour force skills in the labour market, to improve social inclusion of the vulnerable groups, to develop better monitoring and evaluation system and to strengthen social dialogue and capacity of social partners. The conclusion was that civil society organisations should play a more prominent role in social inclusion and poverty reduction. In its evaluation of the progress achieved during 2010,[53] the European Commission has once more, as in the previous period,[54] highlighted the necessity of comparing the Europe 2020 strategy with the JIM implementation measures. Even more importantly, actual outcomes of the implemented measures need to be elaborated in the future progress reports.

As stated in the previous reporting period,[55] the National Implementation Plan for Social Inclusion 2011-2012[56] was drafted and based on the Europe 2020 strategy. However, it did not accomplish the desired impact in 2011, since no progress can be reported on some of its key priorities (i.e. revision of minimum pension, low multi-pillar pensions, remunerated work of pensioners).

It remains to be seen whether the reform and modernisation of the pension system in the upcoming period will follow the recommendations from the Annual Growth Survey 2012,[57] i.e. ensure financial sustainability and adequacy of pensions, by aligning the retirement age with

---

49 The World Bank, cit. (FN 20), p. 11.

50 Ibid., p. 10.

51 The Joint Memorandum on Social Inclusion (JIM) and Joint Assessment of the Employment Policy Priorities (JAP) were signed in 2007 as part of the Accession Partnership between Croatia and the EU. The JIM serves as preparation for full participation in the open methods of coordination on social protection and social inclusion. As both JIM and JAP processes are interdependent, since 2010 they are monitored jointly and presentation of the implemented activities and their outcomes takes place on an annual conference. For more detail, see Croatia ANR 2011, p. 10.

52 Report and presentations from the conference are available at http://www.mzss.hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/jim_jap_konferencija_o_nastavku_aktivnosti_i_provedbi_mjera.

53 The European Commission, DG Employment, Social Affairs and Inclusion, 21.11.2011, retrieved on 13.02.2012 at http://www.mzss.hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/zajednicki_memorandum_o_socijalnom_ukljucivanju_hr.

54 See Croatia ANR 2011, p. 10.

55 Loc.cit.

56 Retrieved on 21.04.2011 at http://www.mzss.hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/zajednicki_memorandum_o_socijalnom_ukljucivanju_hr.

57 European Commission (2011), Communication from the Commission 'Annual Growth Survey' COM (2011)815 final.

increasing life expectancy, restricting access to early retirement schemes, supporting longer working lives, equalising the pensionable age between men and women and supporting the development of complementary private savings to enhance retirement incomes. So far, at least one measure (equalisation of the pensionable age between men and women) is being implemented.

2.2.4 Impact assessment

Financial imbalance poses a major threat to the pension system. Low revenues from contributions, which are insufficient to cover the payment of pensions, are further aggravated by the effects of the financial crisis. In 2010, the system shortfall amounted to HRK 16.3 billion or 4.9% of GDP.[58] The Minister of Finances Mr Slavko Linić admits that the problem of the unbalanced pension system, as the greatest generator of budget deficit, will probably not be solved in the next eight to ten years.[59] Since most of the collected contributions are directed to the first pillar (i.e. 20% for the first pillar participants and 15% for multi-pillar participants), which is based on current redistribution and prone to instability and risks, any deficit is covered from budget transfers. The main reasons for low revenues lies in low contribution rate (one of the lowest in Europe, although the total rate of social security contributions of 37.2% of gross salary is among the highest), low employment rate and the transition cost (shortages in the first pillar are covered from other budgetary revenues, mainly taxes[60]).

Not only financial sustainability, but also pension adequacy is at stake. The findings of the aforementioned study on pensions' adequacy[61] indicate that Croatia faces serious problems regarding pension adequacy in the future. Theoretically, initial net replacement rate (first pension in relation to last salary) for a typical worker (or better said, ideal type of worker: male, with 40 years of service time and 65 years of age at retirement, with no career breaks, insured in first pillar only) is at 55% in 2010 among the lowest in the EU (on average 76%). In 2050, the initial net replacement rate for the worker of the same characteristics, but insured in both pillars, will be 38%. This projection, however, was calculated before the legislative changes regarding the first pillar pension supplement and opening of the gateway for switching to first pillar for optional multi-pillar participants. The net rate of replacement after 10 years of retirement decreases for about 6.5%, mainly due to the Swiss indexation formula, which sets a downward trend for the average pensioner's standard in Croatia.

The World Bank simulations have shown that in order to eliminate differences in replacement rates between first pillar only and multi-pillar beneficiaries, the 27% supplement should either be extended to all multi-pillar participants (at a huge cost of additional 1.2% of GDP annually by 2035 or 3.2% by 2060), completely abolished, or provided to all pensioners on a means-tested basis.[62] As stated in Section 2.2.1. of this ANR, neither of these paths was followed, since the supplement was integrated in the pension and a gateway for optional multi-pillar beneficiaries to return to the first pillar was opened. The World Bank recommends abandoning the Swiss formula of wage-price pension indexation (as it will raise the deficit in 2020 by an average of 0.8% of GDP annually) in favour of the full wage valorisation and price indexation. Projections for the second pillar show that raising the second pillar contribution rate to 10% by 2016 would prevent erosion of future cohort replacement rates. However, this would imply a reduction in the first pillar revenues and consequent transfers from the budget of almost 2% of GDP to cover the deficit. This cost could be cut by half if the basic pension were realigned in

[58] See Croatia ANR 2011; Nestić, op.cit.
[59] Newspaper article, Jutarnji list, 15.02.2012.
[60] In 2010, the amount from the State budget allocated for this purpose was HRK 4.2 billion and this situation will persist for a number of years. See more in Nestić, Danijel, op. cit., p. 13.
[61] Nestić, op.cit., p. 58.
[62] The World Bank, Croatia: Policy Options for Further Pension System Reform, cit. (FN 20).

proportion to a declining first pillar rate. Another option, to raise the overall pension contribution rate would increase labour costs and lower the competitiveness and should consequently be considered only as a last resort. Since all of these measures will have significant impact on the public finances, they need to be accompanied by austerity measures in the pension system.

The issue of pension adequacy is closely related to poverty in old age. The scope of the poverty among pensioners differs depending on the actor defining it. Estimated poverty rate among pensioners ranges from 28.1% (Croatian Bureau of Statistics) to 80% (pensioners' organisations). Higher poverty rates estimates are based on the consumer basket value and its coverage with average pension in the case of two-member family receiving one average pension. Thus, according to the calculations of the Croatian Independent Unions, the pensioners' consumer basket in August 2011 was HRK 3,640.21 and its coverage with average pension was only 59.19%.[63] The Croatian Pensioner's Union, using different methodology and higher poverty line, calculates the poverty rate of pensioners at 80%.[64] However, more accurate results are acquired if a comparison between the total income of pensioners' households (i.e. pensions and other income, taking into account the number and economic power of household members) with the value of the consumer basket is made. Relying on these variables, the proportion of pensioners who cannot cover 100% of the consumer basket is estimated at 28%.[65] This is closer to reality and the official at-risk-of-poverty rates published by the Croatian Bureau of Statistics.[66] Nevertheless, pensions and other social transfers contributed to the reduction of the poverty rate in Croatia in the period between 2004 and 2009 by 60%. The impact of pensions in the total poverty rate reduction was more significant than that of other social transfers (70% of the total reduction is accredited to pensions).[67]

The promotion of pension literacy is extremely important for adequate retirement income. All analyses show that traditional patterns of generational solidarity and relying solely on pensions from mandatory, state funds will not suffice to ensure decent living standards of pensioners in the future. The most recent study[68] shows that 54% of active population in Croatia is pension illiterate. Pension illiterate group is characterised by some common demographic features, attitudes and beliefs. It consists mainly of persons with lower wages or unemployed, with lower education levels, living with their parents or relatives, mostly in rural areas. They have negative attitudes regarding all types of savings, not just those specifically targeted for retirement. Although they believe that they will be dependent on help from others in old age, this group is more ready to plan early retirement. Due to low level of information, they share unrealistic expectations regarding the adequacy of pension incomes and expect much higher replacement rates than the pension literate population. Raising awareness on the individual responsibility for savings in old age, through a national strategy or campaign is necessary.

The labour market participation of the elderly has not improved in the reporting period. No new measures and incentives were implemented to stimulate the remunerated work of pensioners or

---

63 Croatian Independent Unions, retrieved on 10.02.2012 at http://www.nhs.hr/gospodarstvo/kosarica/izvjesca/.

64 Urban, Ivica (2011) Stvarni dohodak umirovljenika in: Zbornik radova Analiza mirovinskog sustava, Banka magazin i Institut za javne financije, Zagreb, retrieved on 11.01.2012 at http://www.bankamagazine.hr/LinkClick.aspx?fileticket=W6kzsdxFPSY%3d&tabid=413.

65 Ibid.

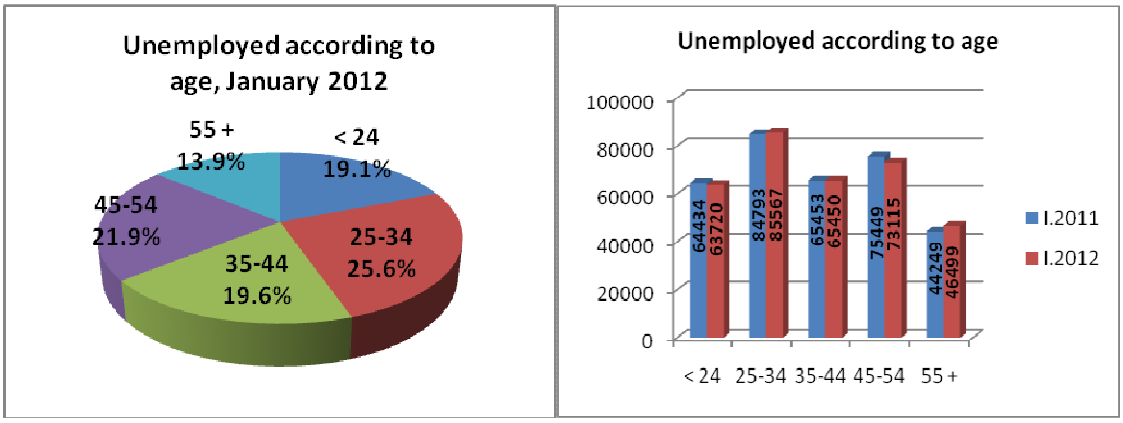
66 The at-risk-of-poverty rate, by age and sex, was the highest in 2010 for persons aged 65 years and over and amounted to 28.1%. In this age group, the difference by sex was the highest and amounted to 31.3% for women and 23.3% for men. Croatian Bureau of Statistics, Poverty Indicators 2010 (released 30.11.2011), retrieved on 10.02.2012 at http://www.dzs.hr/Hrv_Eng/publication/2011/14-01-02_01_2011.htm.

67 Šućur, Zoran (2011), Siromaštvo i dohodovne nejednakosti u Hrvatskoj: 2001.-2009., in: Rev. soc.polit. 18 (2011) 2, p. 245-256, 255.

68 Škreblin Kirbiš, Ivona; Tomić, Iva; Vehovec, Maja (2011) Mirovinska pismenost i štednja za treću životnu dob, Revija za socijalnu politiku 18 (2), p.127-148.

longer stay in the world of work. During 2011, employment subsidies for 50+ employees were continued within the framework of the active labour market policy (ALMP) measures. The latest data show that 305 persons were caught by this measure in 2010.[69] This is only a tiny fragment of the registered unemployed persons in this age cohort (Figure 1).

Figure 1: Registered unemployment according to age in January 2012



Source: Registered unemployment and employment in January 2012, Croatian Employment Service, retrieved at http://www.hzz.hr/docslike/PR_Nezaposlenost-Zaposljavanje_01_2012.pdf.

Apart from the growing number of unemployed, which peaked in January 2012 at 19.8%,[70] the number of unemployed youth (20-24 and 25-29) and older workers (50+) remains high and is particularly worrisome. In December 2011, there were 31,686 newly registered unemployed, which is 18.5% more than in the same period 2010.[71] In 2011, 36,468 new persons were included in the ALMP measures, the majority in educational and public work programmes. The reach of these measures is still very limited, since at the end of December 2011 only one third or 12,707 beneficiaries remained active.[72] The crisis mostly affected the subsidies programmes for employment of workers 50+. In 2008, the rate of coverage i.e. the percentage of unemployed that benefited from this subsidy was 9.4, whereas in 2009 and 2010 that ratio dropped significantly, to 1.8% and 2.3% respectively.[73] Some of the main challenges of the labour market are the low level of active population, demographic determinants, incompatibility of the labour force professional education and skills with labour market needs, high labour costs, low mobility and labour force flexibility, regional disparities. In comparison with the Europe 2020 goal of 75% employment among active population (20-64), the rate in Croatia is at 52.3%. In addition, only 20.6% of the population between 30-34 years of age has higher education.

Given that the sustainability of the social protection systems depends on the revitalisation of the economy and reversal of the negative trends in the labour market, the implementation of the activities and measures in these sectors will be under close scrutiny in the coming months. The Ministry of Labour and Pension System has identified key challenges for activation and

[69] Croatian Employment Service(2011), Statistical Yearbook 2010, retrieved on 20.01.2012 at http://www.hzz.hr/DocSlike/HZZ_Godisnjak_2010.pdf.

[70] In December 2011 it was 18.7%. On 07.02.2012 the number of unemployed was 332,719, which is almost 30,000 more than at the end of 2011, whereas the number of vacancies for the entire country was 4,758. To assure transparency, the new Government made the statistics on (registered) unemployment available on daily basis. The new service "*Statistika on-line*" (http://statistika.hzz.hr) enables searching of the number of registered unemployed, new registrations and exits from the registry, as well as the number of vacancies.

[71] Unemployment benefit is received by 23.8% of the registered unemployed.

[72] Croatian Employment Service (2012), Registered unemployed and employment in December 2012, Zagreb, retrieved on 01.02.2012 at: http://www.hzz.hr/docslike/Nezaposlenost_Analiza_Prosinac_2011.pdf.

[73] Bejaković, Predrag; Gotovac, Viktor (2011), Aktivnosti na gospodarskom oporavku u Republici Hrvatskoj s naglaskom na tržište rada, in: Rev. soc.polit. 18 (2011) 3, Zagreb 2011, p. 331-355, 347.

strengthening of competitiveness in the labour market. The focus will be on the implementation of measures aimed at activation of long term unemployed, legalisation of informal work, lowering of tax load for low skilled workers, active policy measures for strengthening of the employability, accessible information system for professional career development, developing of the system for tracking the labour market needs and linking them to the professional education system, lowering of labour costs, flexibilisation of employment. Special measures will be targeted at young persons with no work experience, older workers, persons with multiple barriers to entry into the labour market, persons with obsolete skills and education and long-term unemployed women. These measures should be implemented in close cooperation with local authorities and the importance of decentralised decision-making on active labour market programmes and policies according to local needs is stressed out.[74]

The other side of the coin when it comes to keeping people in work and working longer are relatively high amount of minimum pensions and (still) mild conditions for early retirement. The minimum pension as % of average net wage in Croatia stands at 32%, which is comparatively high (Figure 2).

Figure 2: Minimum Pension as % of Average Net Wage

Country	%	Country	%
Ukraine	49	Moldova	27
Luxembourg	42	Poland	25
New Zealand	38	Hungary	21
Netherlands	34	Japan	19
Latvia	33	Switzerland	19
Spain	33	US	19
Croatia*	**32 (42)**	Norway	18
Belgium	30	Bulgaria	16
Ireland	30	UK	15
Korea	30	Canada	14
France	29	Czech Republic	12
		Estonia	7

**for 30(40) years of service*
Source: The World Bank (2011) Croatia: Policy Options for Further Pension System Reform, 2011, retrieved on 10.01.2012 at http://siteresources.worldbank.org/INTCROATIA/Resources/Croatia_ Policy_Notes-Pension.pdf, p. 12.

The financial situation is the key determinant for the decision to retire early, as revealed in a recent study.[75] In other words, if the amount of the (early retirement) pension is not significantly lower than the full pension or the current wage, a person will be more inclined towards early retirement. Health reasons are also playing an important role: early retirement is more likely in case a job has adverse impact on the physical or psychological health of the employee (low skilled workforce, low paid jobs).

Statistical information on the gender pension gap shows that the average women's pension is roughly one third lower than that received by men (mainly due to lower retirement age for women). This proportion is almost equal with survivors' pensions, which can be explained by the fact that 90.1% of this type of pensions is received by women. Further analyses of the causes and possible remedies for the gender pension gap are required.

[74] Press conference at the Croatian Employment Service (HZZ), 13 January 2012, materials available at: http://www.hzz.hr/.

[75] Pološki Vokić, Nina; Grgurić, Lana (2011), Upravljanje zaposlenicima starije životne dobi – model djelotvornog upravljanja u hrvatskim organizacijama, in: Rev. soc.polit. 18 (2011) 2, p. 149-174, 162.

Figure 3: Average pension, by type of pension and gender, December 2010.

	Total	Women	Men	Women's pension as percentage of men's
	in kuna			
Total	**2,361**	**2,082**	**2,683**	**77.6**
Old-age pension	2,388	2,139	2,647	80.8
Disability pension	2,502	1,832	2,647	65.8
Survivors' pension	2,110	2,108	2,135	98.7

Source: Croatian Bureau of Statistics (2011), Women and Men in Croatia 2011, Zagreb.

2.2.5 Critical assessment of reforms, discussions and research carried out

At the time of drafting this ANR, the Government Programme for the Mandate 2011-2015 in the field of pensions was still not elaborated and is too general to allow any meaningful comments and assessments. The intended reforms are seemingly pointing into the right direction, but the modalities of their implementation will have to be appraised in the upcoming period. The announced reform of the Croatian Pension Insurance Institute (HZMO) and rationalisation of its operation should, however, extend also to other institutions involved in administration of the first and second pension pillars.

The dependency ratio and replacement rate reached all-times lows in 2011. The dependency ratio in December 2011 was at 1:1.21.[76] The average net replacement rate was 37.55%. Cross-cohort and cross-pillar differences are a major obstacle for the objective of ensuring *adequate retirement income for all and access to pensions*, as shown in a recent study.[77] The problem is that over the years, interventions in the first pillar have eroded the initial purpose of the second pillar, which was to ensure pension growth for future generations in an ageing society. The pillar system is not suited for those who decide to retire early. The second pillar is operating in accordance with reasonable expectations and in comparison with similar systems in other countries. Raising pension literacy and confidence towards the specific type of savings for old age would accentuate the individual responsibility for the adequacy of pensions.

The initial idea behind the second pension pillar is in line with the objective of having *more people in work and working longer*, since it establishes a direct link between work and the amount of pension and should stimulate later retirement. However, the combination of prolonged negative economic trends and frequent interventions in the system have caused periodic increases of the number of pensioners. For example, in the first half of 2010, before entering into force of the more stringent sanctions for early retirement, there was an upsurge of 76% in early retirement in comparison to the same period the year before.[78] This year, the government is planning to file for bankruptcy proceedings of many fully or partially state-owned companies which are unprofitable for a long time.[79] It is to be expected that one part of the employees will probably decide to retire.

Reaching the *appropriate and socially fair balance between contributions and benefits* implies significant cross-pillar differences in the amount of pensions. The multi-pillar pension is underrated in comparison to first pillar pension, especially given the fact that multi-pillar participants pay three fourths of the contributions to the first pillar, but receive pension from

[76] In 1980, the dependency ratio was 1:4.04. A sharp decline starts from the mid-1990ies, from 1:3 in 1990, over 1:1.81 in 1995, to the current ratio. See more in Croatia ANR 2011, p. 11.
[77] Nestić, op.cit., p. 58.
[78] Croatia ANR 2011, p. 7.
[79] Minister of Finances Mr Slavko Linić, novilist.hr, retrieved on 10.11.2011 at http://www.novilist.hr/Vijesti/Gospodarstvo/Linic-U-stecaj-ce-otici-30-tisuca-tvrtki.

the first pillar which is only around 2 times higher than the amount of pension from the second pillar.[80]

Within the objective of *promoting the affordability and the security of funded and private schemes*, most debates are revolving around the improvement of the turnover risk control mechanisms in the second pillar, notably developing resilience to macroeconomic and investment risks through reasonable limitations of investments, portfolio diversification according to age,[81] establishment of the guarantee fund and reforming the system of management and other fees.[82]

Information and transparency should be enhanced if the government implements the obligation to inform the participants about the amount of contributions paid to their account, at least once a year.[83] Establishing a pension calculator, accessible on a website of the Croatian Pension Insurance Institute (HZMO) would also contribute to the overall system transparency.

Policy recommendations

Admittedly, drastic reforms of the Croatian pension system are not necessary. However, it is burdened by structural weaknesses which threaten its stability. They have intensified over the years, only partially due to the economic crisis. Quick, but by no means impulsive policy responses are needed to remedy the outstanding issues:

- Increasing the retirement age or linking it to life expectancy. This is a pressing, but highly political issue which is still not properly analysed and debated in public.
- Considering service time not as one of the criteria for retirement, but rather a determinant of the pension amount.[84]
- Levelling cross-cohort and cross-pillar differences to address the perception of unfairness of the pension system. The confidence in the multi-pillar structure of the pension system has not improved. Quite the contrary, the popular belief, fuelled by the recent legislative amendments and returning of practically almost all of the current optional multi-pillar pensioners under the first pillar, is that the first pillar pensions are much more gratifying and reliable than the multi-pillar ones. Levelling of first and multi-pillar pensions is a difficult issue. Virtually every solution, whether it involves the extension of pension supplement to all pensioners, redistribution and/or increase of the contribution to the second pillar or change of the formula for the basic pension calculation, will be costly for the pension system as a whole. Therefore, it cannot be successfully implemented without revitalisation and strengthening of the economy.
- Increasing replacement rates for multi-pillar pensions and developing better and more efficient incentives for voluntary pension saving. Pension funds have become the major market players in Croatia: They are the largest non-banking investors in the capital market.[85] Average yield of pension funds in 2010 was at 8.64% (in 2009 8.7%).[86] However, their members will not benefit from any higher replacement rates with the

[80] Nestić, op.cit., p. 38.
[81] Portfolio diversification according to risk is advocated by the Association of Pension Funds Management and Pension Insurance Companies (UMFO). See more in UMFO, Mirovinska reforma u Republici Hrvatskoj: dosadašnji učinci, aktualno stanje i prijedlozi za budućnost (2011), p. 25-26, retrieved on 01.02.2012 at http://www.azfond.hr/doc/Mirovinska%20reforma.pdf. Vukorepa warns that it is impossible to predict the impact of that solution without further scientific and expert impact analysis. See Vukorepa, op. cit., p. 257.
[82] Nestić, op.cit., p. 62.
[83] See FN 35.
[84] Nestić, op.cit., p. 59.
[85] The World Bank, cit. (FN 20), p. 16.
[86] In comparison, Austria has the average yield around 6.6% and Germany 4-5%. Štimac, op.cit.

current rate of contribution of only 5% to the second (mandatory) pillar. In addition, more incentives for the savings in the voluntary third pillar are required to make this option more attractive and shift at least some part of the burden for financial safety in the old-age to citizens themselves.

- Reviewing the role of the minimum pension. Its (relatively high) average amount in comparison to the average pension[87] could be the reason for the evasion of contributions. Namely, it is not unusual to register employees to receive minimum wages, which means paying lower pension contributions (consequently, lower pensions in the future, which may be offset by a guaranteed minimum pension).
- Reviewing the criteria for disability pensions. Relatively mild criteria for disability pensions have over the years produced a great number of disability pension beneficiaries (in December 2011 327,928 or 27% of the total number of pensioners[88]). The number of persons receiving some social/disability benefits is estimated at 12,000 per 100,000 inhabitants in Croatia[89], which is among the highest in Europe. Apart from reviewing the permissive regulations (and their potential abuse), in-depth analysis of other possible causes and their effects, such as real health and work conditions, Homeland war and its consequences or linkages between socio-economic status and disability should be conducted.
- Reviewing the pension indexation formula. This implies detailed impact assessment of the current "Swiss" indexation formula in comparison with its alternatives (i.e. full wage or price valorisation) and its potential medium and long-term effects on the sustainability of the system and pension adequacy.
- Strengthening the link between contributions and pensions. This implies stronger supervision of the payment of contributions[90], reviewing of early retirement conditions (shortening the period allowed for earlier retirement) and gradual conversion of privileged pension systems to the general system.
- Review the administrative costs of (first and second pillar) pension institutions. Administrative costs of institutions managing the first and second pension pillar[91] need to be rationalised.
- Establishing appropriate framework for social pensions. The elderly without income should not be left to the social welfare system only. Introducing the tax-financed "zero" pillar based on the means-assets test is suggested as the most appropriate solution for this issue.[92] However, it is also the one which is persistently pushed aside.[93]

---

87 See Croatia ANR 2011, p.15.

88 The Croatian Pension Insurance Institute (2012) Statističke informacije 4/2012. Retrieved on 10.02.2012 at http://www.mirovinsko.hr/UserDocsImages/publikacije/statisticke_informacije/2011/4/Statisticke_informacije HZMOa_4_2011_veljaca2012.pdf.

89 World Health Organization (2011) European Health for All Database, retrieved at http://data.euro.who.int/hfadb/linecharts/linechart.php?w=1280&h=800.

90 The new Minister of Finances Mr Slavko Linić announced that the banks will be charged to control that all contributions are paid at the same time with the payment of wages (although the obligation of simultaneous payment already exists, it is not implemented in practice). The banks have, however, replied that this is not technically possible. See more at: http://www.business.hr/ekonomija/bankari-o-linicevoj-naplati-doprinosa-to-je-dobra-ideja-no-mi-ju-ne-mozemo-i-necemo-provesti.

91 The Croatian Pension Institute (HZMO), The Central Registry of Insured Persons (REGOS), The Croatian Financial Supervision Agency (HANFA) and compulsory pension funds.

92 See Croatia ANR 2011, p. 15; Puljiz, Vlado (2011), Kriza, reforme i perspective mirovinskih sustava u europskim zemljama i Hrvatskoj, in: Privredna kretanja i ekonomska politika 129 (2011), Zagreb, p. 27-64, 59; Nestić, op.cit., p.62.

93 As reported in Croatia ANR 2009, 2010 and 2011.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The system of health care in Croatia is based on mixed financing and the combination of public and private health services. Health protection is financed from mandatory contributions (approximately 80%) as well as from taxes. Health protection is financed by the Croatian Institute for Health Insurance (HZZO), counties and the City of Zagreb and beneficiaries. Rates of contributions will, as of 1 March 2012, decrease from 15% to 13% (measure implemented with the aim of increasing competitiveness of the economy) for the basic health insurance. 0.5% contribution is paid as a special contribution in case of occupational injuries. Contributions are paid on the monthly contribution base, which represents the salary or other income from employment paid by employer and subject to income tax or income from self-employment, which is calculated as the product of monthly contribution base and a coefficient depending on the nature of self-employment. Health contribution on pensions above average net wage is paid in the amount of 3%. It is estimated that only 1/3 of the population is liable to pay health care contributions, while the remaining population includes pensioners (if the amount of pension is up to the average net wage, 1% health contribution is paid from the state budget), insured persons' family members, unemployed (health contribution 5% of the prescribed base amount, paid from the state budget) and other inactive persons.

Hospitals are financed directly from the state budget (based on the contract concluded with the HZZO), while all other payments are effectuated through the HZZO. Clinical medical institutions receive during the year the maximum amounts to perform clinical and specialist-consiliary medical care and at the end of the year the work performed and the allocated means are harmonised. The treatment of acute patients is paid to clinical medical institutions according to diagnostic-therapeutic groups (DTS), or according to day of clinical (hospital) treatment (DBL) for chronic diseases. Additional coverage is provided for particularly expensive medicines and certain complicated procedures. In year 2010, 21,195 beds have been contracted, 15,963 of which are acute beds and 5,962 beds for chronic diseases, prolonged treatment and physical therapy.[94] Monthly hospital limit in 2011 was HRK 687.09 million. According to structure, the majority of hospital expenses cover employees' wages (56.67% in 2010, 57.38% in 2011).[95] The amount of co-payment for services in primary health care and for prescription medicines is currently HRK 10.

Facilities involved in health care activities are either state- or county-owned, or private. Teaching hospitals, clinical hospital centres and state institutes of public health are state-owned. Health centres, polyclinics, general and special hospitals, pharmacies, institutions for emergency medical aid, home care institutions and county institutes of public health are county-owned. The number of health centres has steadily decreased from 120 in 2002 (when the process of merging began) to 49 in 2010. Out of 71 hospital institutions and sanatoriums, seven special hospitals and four sanatoriums were privately owned. By the end of 2010, there were 6,223 private practice units (doctors' offices, laboratories, private pharmacies, private physical therapy practices and home care services) registered.

By the end of 2010 Croatia's health care had a permanent work force of 72,207 (54,873 health professionals and associates, 5,117 administrative and 12,217 technical staff). Structure wise, the most permanently employed workers were of high school education (38.2%). Administrative-technical staff had a 24.0% share, physicians 17.1% share in the work force.

[94] Croatian Institute of Health Insurance (2011), Izvješće o poslovanju zdravstvenih ustanova za 2010. godinu.

[95] Ostojić, Rajko (2012), Health care system condition, presentation at the round table organized by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.

Additional 8,270 health professionals and associates were temporarily employed in the same period.

In 2010, roughly 75% of permanently employed physicians worked in state health institutions (primary job). Permanently employed medical doctors had a share of 60.1% women, and 66.9% specialists. By the end of 2010, there were 945 additional part-time physicians.[96]

In 2010, 76% of the total insurees count (4,510,328) used primary health care services.

The procedure for granting concessions in primary health care and the reform of emergency health care continued in 2011.[97]

The introduction of concessions in 2010 was aimed at reforming the existing (and quite unique) solution of rentals and private contracted physicians in primary health care. Given that the procedure of granting concessions proved difficult and time-consuming in practice, the deadline for the completion of the process was prolonged for another 6 months (i.e. until 30 June 2012).[98]

The weak points of the reform of emergency health care were revealed in 2011. Regional emergency medical institutes were established in each county. However, there was no prescribed deadline for the beginning of their operation and organisational problems regarding the obligatory separation of sanitary from emergency transportation have arisen. In some areas, this solution proved complicated or unnecessary and would have implied the impossibility to redirect sanitary to emergency transportation in cases of urgencies. Therefore, the legislative changes in 2012 attempt to correct this anomaly by providing the possibility of keeping sanitary transportation within the regional emergency medical institutes and setting the deadline for the beginning of their operations by 30 June 2012.[99] The option of keeping the 'cold' transportation within the emergency medical institutes is only part of the solution. The success of the reform depends on achieving the planned coverage of at least one emergency medical team (T1: doctor, nurse, driver or T2: two medical technicians, at least one with specialised emergency medicine training) in the radius of 25 km. There were reported instances of patients not receiving the required emergency treatment in time, because the only emergency team for that local area was busy on another intervention.[100] These occurrences have also brought forward the issue of insufficiently equipped primary health care medical practices (e.g. the lack of reanimation equipment).

According to the Draft State Budget 2012, the budget of the Ministry of Health will decrease by HRK 600 million. In preparation for this cut, the Act on Amendments to the Obligatory Health Insurance Act was proposed in February 2012.[101] The highest amount of participation of insured person in the costs of a medical service is cut from 90.2% (HRK 3,000) of the budget base to 60.13% of the base (HRK 2,000). On the other hand, the compensation of the travel costs incurred for obtaining a medical service will be awarded only if the treatment was

[96] Croatian Public Health Institute (2011), Croatian Health Service Yearbook 2010.
[97] See Croatia ANR 2011.
[98] Act on Amendments to the Health Protection Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 12/12. If local and regional self-governing units do not complete the procedures until that time, the Ministry of Health will take them over and finish until 31.12.2012 at the latest. Private physicians who have rented premises in health centres in accordance with the old regime and who perform specialties for which concession is not granted have the option of either entering into employment relation with the respective health centre or continue to rent the same premises as private physicians and under commercial terms.
[99] Act on Amendments to the Health Protection Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 12/12.
[100] Newspaper articles: Novilist, 05.11.2012; Danas.hr, 04.01.2012.
[101] Draft Act on Amendments to the Obligatory Health Insurance Act, retrieved on 16.02.2012 at http://www.sabor.hr/Default.aspx?art=46349.

obtained in the facility which is more than 50 km distant from the patient's residence (the threshold for entitlement prior to the amendment was 30 km). Given that financial consolidation of the health care system with the establishment of appropriate mechanisms for unified management of benefits, the deadline for separating the administration of HZZO from the State Budget is postponed to 01 January 2013.

2.3.2 Debates and political discourse

With the new government in office, another redesign of health policy will ensue. According to the Government Programme for the Mandate 2011-2015, the present health policy needs to be refurbished, since over the years it has shifted more and more financial expenses from state to citizens. The Programme states that the right to health, accessible and high quality health care and medicine presently mostly depends on the financial capacity of individuals. The shift towards patient-oriented health policy, with triple solidarity (between healthy and ill, rich and poor and young with elderly) is announced. This should be achieved through a number of measures, such as reorganisation of emergency medical care, primary health care and hospitals, education of human resources, more accent on preventive measures, shortening of the waiting lists.

The Minister of Health Mr Rajko Ostojić presented the new Strategic Plan of the Ministry of Health for 2012-2014.[102] Within the general objective of the protection, preservation and improvement of health, three specific targets are set. The first specific target is more accessible health protection. It implies reorganisation and improvement of the emergency medical services, completing the public health services network, development and standardisation of health infrastructure and investment in human resources, informatisation of the health system, organisation and implementation of services of telemedicine, guaranteeing realisation of health insurance rights and involving patients' associations in decision-making process. The second specific target is to develop the appropriate quality assessment system in health care. The third specific target is the protection of public health interests, through improvement of national transplantation programme, appropriate framework of sanitary supervision and better monitoring and protection of employees' health.

The future activities will be mainly directed at achieving cost-effectiveness in hospital sector and include: restructuring and rationalisation of acute hospital capacities (drafting of masterplan), centralisation of hospital procurement of electricity, postal services and consumable supplies, rationalisation of non-medical activities of hospitals through outsourcing and spin-off, drafting of the national classification and centralisation of procurement of financially most expensive medical products and prostheses. Cost containment for prescription medicines will be applied. Incentives for private health insurance are planned with the objective of redirecting a part of health demand to these sources.

Uneven distribution of health care facilities and diagnostic equipment[103] will be addressed in the upcoming period.

Public debate on health care issues and system sustainability is intensified through the project "Analysis of Health Care System". The project was modelled on the already existing project "Analysis of the Pension System" (see in Section 2.2) and launched in 2012 by Magazine Banka and the Economic Institute Zagreb, under the auspices of the Ministry of Health. A series of public discussions and analyses are foreseen, primarily by researchers from the

[102] Ostojić, op.cit.

[103] See Croatia ANR 2011, p. 23. Just one of the anomalies pointed out by the Minister of Health Mr Rajko Ostojić is the fact that Velika Gorica, the 6th largest city in Croatia, has no hospital and all patients gravitate to hospitals in the neighbouring capital city of Zagreb.

Economic Institute Zagreb, but also other professionals and academics who specialise in this subject.[104]

The World Health Organisation strategic recommendations for Croatia highlight the need for addressing lifestyle and risk factors by scaling up promotion and prevention of noncommunicable diseases. The main challenges of the (slow) health sector reforms are seen in centralised management and relatively underdeveloped stewardship capacities of national authorities in health system planning.[105] Integration with the EU is regarded as an opportunity to receive potential financial assistance to health sector from EU funds.

2.3.3 Impact of EU social policies on the national level

Within the new Strategic Plan of the Ministry of Health for 2012-2014[106], better accessibility and quality of health care are key priorities, which is in line with the OMC objectives. However, given that the Plan was not published, detailed assessment of congruence of the proposed measures with OMC objectives is not possible.

The age group 65+ is the leading age group according to the number of hospitalisations, with 293.77 hospitalisations per 1,000 inhabitants of that age group.[107] This means that the linkage between health and ageing is still not appropriately addressed. Better solutions for healthy ageing and more years spent in good health need to be devised, with the accent on preventive actions.

Linkage between health and poverty requires closer attention in the future. The Minister of Health compares the number of persons who are exempted from out-of-pocket payments (around 900,000) to the estimated number of persons who live below the poverty threshold in Croatia (around 800,000).[108] However, this comparison is not an indicator of accessibility of health protection for those below the poverty line, since the basis for exemption is not means-assets test. Categories of persons who are exempted from payments are children, pregnant women, HIV positive patients, chronic psychiatric patients, persons with organ transplantations and undergoing dialysis as well as persons suffering from malignant diseases. A series of public opinion surveys revealed that health and health care system were consistently among the top two issues in all elections from 2005 to 2009 (presidential elections in 2005 and 2009 and parliamentary in 2007).[109] Interestingly, respondents with lower household income, unemployed or part time employed considered health care issues considerably more important than respondents with medium or higher income. The average household consumption on health in 2010 was HRK 2,349 or 3.25% of total household consumption,[110] which leads to conclusion that the poorer will have more difficulties in meeting the costs for health care.

---

[104] The first round table was organized in February 2012.

[105] World Health Organization (2010), Country Cooperation Strategy at a glance, retrieved on 12.12.2011 at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_hrv_en.pdf.

[106] Not available online, presented by the Minister of Health at the round table organized by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb.

[107] Croatian Institute of Public Health (2011) Rad bolnica i bolnički pobol u Hrvatskoj 2010, retrieved on 10.02.2012 at http://www.hzjz.hr/publikacije/bolnicki_2010.pdf, p. 9.

[108] Ostojić, op.cit.

[109] Radin/Džakula/Benković (2011), Health Care Issues in Croatian Elections 2005-2009: Series of Public Opinion Surveys, Croat. Med. J. (2011) 52, 585-92.

[110] Croatian Bureau of Statistics (2011), The Household Budget Survey, First Release, 28.10.2011, retrieved on 10.02.2012 at http://www.dzs.hr/. In comparison with the previous year, health expenditures increased from 2.77% in 2009, mainly owing to increased out-of-pocket payments and medicinal products. See Croatian Bureau of Statistics (2011), Results of Households Budget Survey 2009, retrieved on 10.01.2012 at http://www.dzs.hr/Hrv_Eng/publication/2010/SI-1426.pdf.

2.3.4 Impact assessment

Electoral rhetoric is melting in the face of reality. In one of his first interviews after the constitution of the new Government, the new Minister of Health claims that the financial situation in Croatian health care is far worse than his predecessor had alleged.[111] Consequently, the announced reforms will have to proceed at a slower pace than planned.

There are a number of issues which burden the health care system.

Health care expenditures in 2009 stood at 7.8% of GDP (OECD average 9.6%).[112] Total health expenditure per capita was USD 1,552 in 2009.[113] Public sector health expenditure, as total of health expenditure in 2009 was estimated at 84.88% (OECD average 72%); whereas public sector health expenditure as % of total government expenditures was 17.58% in 2009 (OECD average 22%). Private households' out-of-pocket payments in 2009 amounted to 14.52% of total health expenditure.

Figure 4: Selected basic statistics for Croatia, WHO estimates

Indicator	Year	Value
% of population aged 0-14 years	2010	15
% of population aged 65+ years	2010	17
Crude death rate per 1,000 population	2010	12
Estimated infant mortality per 1,000 live births (World Health Report)	2009	5
Estimated life expectancy, (World Health Report)	2009	76
Hospital beds per 100,000	2009	537
Infant deaths per 1,000 live births	2010	4
Life expectancy at birth, in years	2010	77
Life expectancy at birth, in years, female	2010	80
Life expectancy at birth, in years, male	2010	74
Live births per 1,000 population	2010	10
Mid-year population	2010	4,417,781
Physicians per 100,000	2009	267
SDR all causes, all ages, per 100,000	2010	790
SDR, diseases of circulatory system, all ages per 100,000	2010	371
SDR, external cause injury and poison, all ages per 100,000	2010	53
SDR, malignant neoplasms, all ages per 100,000	2010	211
Total health expenditure as % of gross domestic product (GDP), WHO estimates	2009	8
Tuberculosis incidence per 100,000	2010	16

Source: World Health Organisation, European Health for All database (HFA-DB).

The total deficit of health care system amounts to HRK 5.2 billion (out of which HRK 2.2 billion is the deficit of HZZO (if payment deadline of 60 days is observed) and HRK 3 billion represents the debt of health care institutions). Hospitals are the most indebted facilities. The

[111] Newspaper article, interview with the Minister of Health Mr. Rajko Ostojić, Novi list, 11.01.2012.
[112] Mihaljek, Dubravko (2012), Financing Health in Times of Crisis, presentation at the round table organized by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.
[113] WHO estimates, European Health for All database (HFA-DB).

majority of hospital expenses are for wages of employees (57.38% in 2011), followed by medicines and other medical products (23.43%).[114] Additional expenses in 2012 will include the new organisation of emergency medical services (HRK 117 million), prescription medicines (HRK 260 million) and implementation of rights granted in new collective agreements for health care (HRK 230 million). Prescribed payment deadlines (30 days for obligations assumed after of 1 January 2012, exceptionally 60 days in contractual relationship in which a public entity is a debtor[115]) are unrealistic in view of the size and current dynamics of servicing the outstanding debt. A chain of delayed payments starts with HZZO, and transfers from hospitals over to suppliers and their partners (for example, clinical hospital centres in Zagreb are late with payments up to 260 days, in Rijeka up to 500 days and in Osijek up to 700 days[116]). There is no room for increasing out-of-pocket payments. Due to the already implemented measures[117] the amount of out-of-pocket payments has more than doubled since 2008 (from HRK 651,881,154 in 2008 to HRK 1,406,824,617 in 2010). This has lead to the increase of health care costs in total household costs, i.e. a part of the burden of health care financing was transferred to citizens whose budgets are already affected by economic crisis.[118]

Out of five categories of medical professionals, Croatia is experiencing a shortage of medical professionals in comparison with the EU when it comes to nurses and medical technicians, midwives, doctors and pharmacists. Only the number of dentists is at the EU average.[119] According to the Minister of Health, the outflow of 500 doctors and 1,500 nurses is expected in the first year of Croatian accession to the EU (2013). However, it is estimated that 50% will return after 1-2 years.[120]

The waiting lists for diagnostic and therapeutic procedures differ significantly between institutions, depending mainly on their category, contracted activities and other features (such as location etc.). The three most common reasons for long waiting lists are shortages of physicians, equipment (insufficient number or old and outdated medical appliances) and materials (i.e. prostheses etc.). Other reasons are on the demand (patient) side: many patients choose a certain institution or make appointment to see a specific physician, schedule for the same procedure in several institutions, or fail to show up at the appointment. For example, the longest waiting time for CT procedures is in General Hospital Slavonski Brod (122 days), whereas that period is up to 60 days in hospitals in the 4 largest cities (Zagreb, Split, Rijeka, Osijek).[121] Waiting for MR procedures takes 296 days in Slavonski Brod in comparison to 15 days in Gospić (in other centres it is about 90 to 160 days).

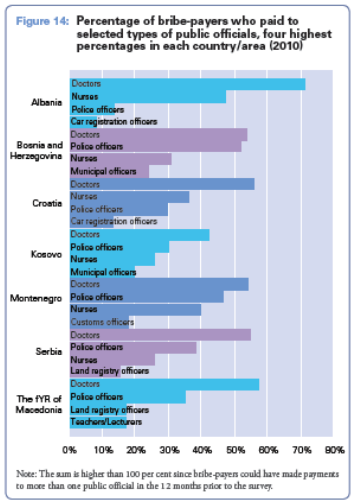
However, analyses show that Croatia has 1.62 CT scans per 100,000 inhabitants (EU standard is 1.45) and 10.32 MRI scans per 1,000,000 inhabitants (which is only slightly lower than the EU average of 11.19). This shows their unequal distribution and diminishes the effectiveness of

[114] Ostojić, op.cit.
[115] Act on Payment Deadlines, Official Gazette of the Republic of Croatia, *Narodne novine* no. 125/11.
[116] Newspaper article, interview with the Minister of Health Mr Rajko Ostojić, Novi list, 11.01.2012.
[117] The number of persons exempted from out-of-pocket payments reduced from 1.5 million to 900,000; out-of-pocket payments for hospital and dentist services increased up to 20% of their value; out-of-pocket payments of HRK 10 per visit and per prescription in primary health care implemented; supplementary health insurance premium increased; the number of supplementary insured persons increased from 650,000 in 2008 to 1.44 million in 2010.
[118] 3.24% in 2010 in comparison with the average of 2.55% in the period between 2005-2008. Švaljek, Sandra (2012), Last Health Reform: Search for Additional Means or Something Else?, presentation at the round table organized by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.
[119] Newspaper article, interview with the Minister of Health Mr Rajko Ostojić, Novi list, 11.01.2012.
[120] Loc.cit.
[121] National Waiting List, November 2011, retrieved on 09.01.2012 at http://www.mzss.hr/zdravstvo_i_socijalna_skrb/nacionalna_lista_cekanja.

their application. The waiting times for hip and knee prostheses or cataract surgeries, which typically affect older population, are in some regions up to three years (for example in Koprivnica 986 days for knee prosthesis[122]). The Ministry of Health intends to deal with this issue by supplying additional material and equipment, developing synergies between public and private sector, adjusting working hours to patients' needs, opening of daily hospitals, increasing productivity and efficiency and implementing full informatisation of the system.

Corruption in health care remains relatively high. Although petty corruption is generally low, the main exception is the health care system, where 15% of respondents report having to make irregular payments to get the necessary service.[123] The highest percentage of bribe-payers gave bribe to doctors (56%) and nurses (36%). The main reasons for getting involved in bribery are to receive better treatment and/or to speed up procedure or avoid long waiting times.[124]

Figure 5: Percentage of bribe-payers who paid to selected types of public officials, four highest percentages in each country/area (2010)



Source: United Nations Office on Drugs and Crime (UNODC) (2011), Corruption in the Western Balkans: Bribery as Experienced by Population, retrieved on 10.02.2012 at http://www.unodc.org/documents/data-and-analysis/statistics/corruption/Western_balkans_corruption_report_2011_web.pdf.

2.3.5 Critical assessment of reforms, discussions and research carried out

The main reproach for all of the health care reforms so far is that they did not pay sufficient attention to professional opinion and experiences of those directly involved in the provision of health care, i.e. medical professionals. The practical issues they encounter on everyday basis are invaluable for creating appropriate strategies and policies responsive to the actual needs and weaknesses of the system. The most recent reforms in 2008 and 2010 have been presented as a serious of PowerPoint presentations, with no strategic papers or projections which could be analysed and scrutinised in public. It remains to be seen whether this practice will be abandoned and whether the bottom-up, patient-oriented approach will prevail in the current and future discussions.

[122] Data for November 2011. In February 2011 the waiting time for the same operation was shorter – 792 days. See Croatia ANR 2011.

[123] European Bank for Reconstruction and Development (2011), Life in Transition Survey II retrieved on 05.02.2012 at http://www.ebrd.com/pages/research/publications/special/transitionII.shtml, p.71

[124] United Nations Office on Drugs and Crime (UNODC) (2011), Corruption in the Western Balkans: Bribery as Experienced by Population, retrieved on 10.02.2012 at http://www.unodc.org/documents/data-and-analysis/statistics/corruption/Western_balkans_corruption_report_2011_web.pdf, p. 24.

Insufficient preparation for the reform of emergency health care has had a negative impact on the accessibility of services. Some county institutes were not prepared and did not have enough resources to assure appropriate coverage for their entire areas, since the procedures for contracting ER teams in certain geographical areas with HZZO were not completed in due time.[125] Reports on three patients dying practically at the (locked) doorstep of emergency medical facilities in the short time after the reform started, because there was no one there to help them, are said illustrations of the system failures.[126] Due to lack of staff and proper training, as well as low level of consultation and participation of doctors and patients in the preparation of the reform, the beginning of the implementation of emergency health care reform should have been postponed.

Sustainability of the system in the future period will mainly depend on ensuring more efficient administration of hospitals. Fostering treatment in daily hospitals for less complicated procedures from which patients recover immediately will certainly reduce the average length of stay in hospitals, which is higher than the EU and region average, although the total number of hospitalisations per 100 inhabitants is lower than the EU average.

Figure 6 a: The average length of stay in hospitals in 2009 (in days)

Country	Average length of stay, all hospitals	Average length of stay, acute hospitals
Hungary	10.5*	5.9*
Czech Republic	10.0	7.4
Croatia	9.5**	7.2**
Slovakia	8.3	6.7
Austria	7.9	6.8*
Slovenia	6.9	5.6
Poland	5.9*	n/a
EU	8.6*	6.7*

[125] For example, in Dubrovnik-Neretva County the County Emergency Medical Institute did not have enough resources to pay additional teams who would remain on stand-by in the towns of Metković and Ploče when the only team in the shift is out on intervention or transporting a patient to the nearest hospitals in Dubrovnik or Split (100 - 140 km or four hours drive distant). The situation will aggravate in the summer with the beginning of the tourist season, when the number of potential patients rises up to 60,000. Danas.hr, 04.01.2012.

[126] Newspaper article, Jutarnji list, 12.11.2011.

Figure 6 b: The number of hospitalisations per 100 inhabitants in 2009

Country	Total number of hospitalisations per 100 inhabitants, all hospitals	Total number of hospitalisations per 100 inhabitants, acute hospitals
Austria	28.1*	26.7*
Hungary	20.8*	17.9*
Czech Republic	20.6	19.4
Poland	18.9*	n/a
Slovakia	18.9	17.1
Slovenia	17.9	17.1
Croatia	16.8**	15.4**
EU	17.7	15.6*

** data for 2008; ** data for 2010*

Source: Croatian Institute of Public Health (2011) Rad bolnica i bolnički pobol u Hrvatskoj 2010 (Hospitals and hospitalisations in 2010), retrieved on 10.02.2012 at http://www.hzjz.hr/publikacije/bolnicki_2010.pdf.

Another Croatian particularity is that primary health care practitioners in general are reluctant gatekeepers. The system throughput ratio, i.e. the share of specialist and polyclinical examinations in comparison to the total number of primary health care examinations is relatively high: one specialist examination to each 1.8 examination in primary health care.[127]

The number of persons with supplementary insurance, administered solely by HZZO, has grown from 650,000 in 2008 to 1.44 million in 2011. However, even with the elevated revenues, the supplementary insurance system was in deficit (roughly HRK 260 million in 2010),[128] which, as pointed out by Švaljek, leaves open the issue of the amount of the premium and adverse selection.[129] Arguably, the weaknesses of the system lie in the fact that the supplementary insurance policy is paid from the state budget for the persons who are exempted from out-of-pocket payments, as well as the fact that up to 50% of supplementary insurance policies are concluded by pensioners (which pay lower rate if the pension is below average wage and which make 25% of the population).[130]

Although a legal base for HZZO to enter the market of additional (voluntary) insurance (extra standard) was introduced in 2010,[131] it has still not embarked on this possibility. Nevertheless, private medical insurance companies anticipate unfair competition given the dominant position

[127] Newspaper article, interview with the Minister of Health Mr Rajko Ostojić, Novi list, 11.01.2012.
[128] Croatian Institute of Health Insurance (2011), Izvješće o poslovanju Hrvatskog zavoda za zdravstveno osiguranje za 2010.
[129] Švaljek, Sandra, op.cit.
[130] Smolić, Šime (2011), Nekima Švicarska nekima gorka pilula, Banka, retrieved on 16.12.2011 at http://www.bankamagazine.hr/Naslovnica/IzBanke/tabid/393/View/Details/ItemID/74463/ttl/Nekima-Svicarska-nekima-gorka-pilula/Default.aspx. The author concludes that the financing of the system has become more regressive, the balance in equality of access to health care services has been disturbed and that the lower income groups have less access to those services.
[131] Act on Amendments to the Voluntary Health Insurance Act, Official Gazette of the Republic of Croatia, *Narodne novine* no. 71/10.

and power of HZZO in the obligatory and supplementary medical insurance market (monopolist).[132]

Policy recommendations

- The implementation of the reform of the emergency medical care needs to be closely monitored in the upcoming period.
- More weight should be given to the financing and organisation of preventive health activities, including preventive health check-ups for target groups, as well as regular and wide-spread education campaigns on the importance of prevention, exercise and healthy nutrition and lifestyle.
- Better management of hospital facilities and reduction of waiting lists will have positive effects on corruption and informal payments in health care.
- Strategic plans and documents, as well as all relevant data on the financing and operation of the health care system should be more easily accessible. Only performance measurement which is based on clear and comparable indicators will offer the opportunity for appropriate decision-making and steering of the system reforms.
- Public-private partnerships in health care need to be more transparent to avoid overpricing of publicly funded, but privately provided services.
- Finding the appropriate modalities for engagement of non-medical staff in hospitals would contribute to reducing high percentage of total hospital expenses for employee's wages.
- Preparation for the expected outflow of the number of medical professionals at the time of Croatian accession to the EU should start immediately. Sound management and coordination of entry quotas for education for deficitary professions will have to be based on thorough analysis and forecasts of the labour market needs.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care in Croatia is organised within the system of social welfare, at the national as well as the regional level. Health protection for the elderly and infirm is provided through the health care system.[133] The legal framework for social benefits includes two new Acts adopted in 2011 within the social welfare reform package: the new Social Welfare Act[134] and the new Foster Families Act,[135] as well as numerous by-laws.

Long-term care is organised on the principle of social assistance and financed mainly from the state budget (96%), while the remainder comes from beneficiaries' participation in payment of costs of care outside one's own family. Local and regional self-governing units participate in the financing of the system and organisation of social welfare services within the scope of their competences. There are no available specific data on long-term care expenses. In 2009,

[132] In its Decision of 15.12.2011, the Croatian Competition Authority (AZTN) refused the initiative of the Croatian Insurance Office (HUO) to find that HZZO is abusing its dominant position in the additional insurance market, as HZZO has still not entered that market.

[133] I.e. the right to health visitor, the right to sanitary transportation, to right to home health care.

[134] Official Gazette of the Republic of Croatia, *Narodne novine* no. 57/11. Upon its entering into force on 02.06.2011, it repealed and replaced the old Social Welfare Act (Official Gazette of the Republic of Croatia, *Narodne novine* no. 73/97, 27/01, 59/01, 82/01, 103/03, 44/06, 79/07).

[135] Official Gazette of the Republic of Croatia, *Narodne novine* no. 90/11. Upon its entering into force on 10.08.2011, it repealed and replaced the old Foster Families Act (Official Gazette of the Republic of Croatia, *Narodne novine* no. 79/07).

expenses for financing of the social welfare system amounted to 0.89% of GDP.[136] The share of beneficiaries of permanent social assistance in total population in 2010 stood at 2.3%, which is an increase of 0.2% as opposed to 2009 (2.1%).[137]

The new Social Welfare Act is the result of a comprehensive social welfare reform, which includes the reform of cash benefits, the system of social services, the mode of their financing and the system of public social welfare centres. The primary objective was to simplify the system and provide better and more efficient access to services and benefits, establish clearer division between cash benefits and social services and rationalise the network of social services centres. Previous 15 cash benefits with different criteria and conditions for obtaining were reduced to eight, better targeted and defined ones. Deinstitutionalisation and the role of private providers of social services are emphasised. However, given that the current reform is the product of previous government concepts, upon taking office, the new Minister of Social Policy and Youth Ms Milanka Opačić announced another revision and possible restoration of the old social welfare system. Actual proposals have not yet been tabled or presented to the public.

Following the basic income and/or specific needs classification,[138] the new Social Welfare Act enumerates eight categories of social welfare beneficiaries. Among them are 'persons who are, due to old age or dependence, unable to provide for their basic personal needs' and 'adults with disability' (Article 30).

Social welfare beneficiaries are entitled to cash benefits, benefits in kind and social services.

There are currently eight cash benefits according to the Social Welfare Act (Article 39): allowance for support, housing, education, one-off cash allowance, personal disability allowance, allowance for assistance and care, parent caregiver allowance and inclusive allowance.

The allowance for assistance and care, for example, is granted to persons unable to care for themselves, on a permanent or temporary basis. Means-testing is applied, meaning that a person is eligible for this kind of assistance if his/her income in the three months preceding the application does not exceed 200% of the base amount (per family member) or 250% of the base amount (single persons) (Article 80 (1) Social Welfare Act). Large cities and cities which are the seats of counties are obliged to provide other types of material support and assistance, including the stimulation of volunteering and work of civil society organisation. Elderly people mostly rely on the allowance for support, the allowance for assistance and the care at home and personal disability allowance.

Currently, the basis for the realisation of social welfare benefits amounts to HRK 500 and it is determined under the decision on the basis for the implementation of the social welfare rights.[139]

Social services are temporary or permanent activities aimed at prevention, recognition and resolution of problems of individuals, families and other groups in the community, as well as raising the overall quality of life in the society. There are ten categories of social services, which are basically social benefits in kind. In-home assistance and care is an example of a social service. It implies the provision of different practical forms of help, prescribed in by-laws (typically includes delivery of meals, housework, and assistance with personal hygiene). It

[136] Ministry of Health and Social Welfare (2011), Social Welfare System Development Strategy 2011-2016. Of this, 64.5% are payments of allowances and other benefits to the beneficiaries.
[137] Ministry of Health and Social Welfare (2011), Report on the Implementation of the Joint Inclusion Memorandum (JIM) of the Republic of Croatia in 2010, p. 115.
[138] See, for example, Babić, Zdenko (2008), Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj, *Privredna kretanja i ekonomska politika* 116/2008, Ekonomski institut, Zagreb, pp. 53 – 81, 64.
[139] Official Gazette of the Republic of Croatia, *Narodne novine* no. 30/08.

is awarded to persons with secured housing and other living conditions, but who are, due to old age, disability or other grave health conditions unable to take care of their personal needs alone or with help from their families. The condition for receiving this social service is that the assistance cannot be obtained from parents, spouse or children, nor based on life maintenance and support agreements or other regulations.[140]

There also exists a range of institutionalised forms of care, e.g. permanent or temporary accommodation or even daily or shorter stays in care centres.

The new Social Welfare Act includes the provisions regarding generational solidarity, whose purpose is to "improve the quality of life of elderly".[141] Under the Act, elderly persons are defined as persons belonging to the age cohort 65+, however, even persons under this age threshold are eligible for this type of services if they are indispensable due to temporary severe health aggravation, and are provided for the duration of such condition. Generational solidarity is defined as the activity for developing and expanding non-institutional services and volunteering, with the objective of keeping the elderly in their own homes and family, their social inclusion and improvement of their quality of life. The services include "different types of services to persons with secured housing and other living conditions, who, due to old age, exclusion, diminished functional capacities or other severe changes of their health conditions, are unable to take care of their basic personal needs alone or with the help of their family member, and are in need of assistance" (Article 120 (2)). The services are generally stated to include assistance with household and other activities, assistance with social integration and other assistance indispensable for the beneficiary. The task of the ministry responsible for generational solidarity will be to organise various activities and services for proactive spending of free time, with the aim of promoting social integration and inclusion and participation of volunteers from all age cohorts. The services are provided by legal and natural persons, who have signed a contract with the ministry, or within family centres. The competent minister prescribes minimum quality standards and other criteria for the provision and participation in payment of such services.[142]

In 2010, the total of HRK 58.1 million was utilised for the implementation of social services of generational solidarity (day care services and in-home assistance), as well as the improvement of work quality. HRK 44.2 million was financed from the State budget of the Republic of Croatia, while the share of co-financing born by the local and regional self-government units amounted to HRK 13.9 million. The amount of HRK 46.7 million is earmarked in the current budget draft for non-institutional services for elderly in 2012, without mentioning specific programmes which will be funded.[143] This is approximately at the level from 2010 and 2011. Given that the results of both of these programmes of generational solidarity are satisfactory, there is no reason to believe that they will be discontinued.

---

[140] In October 2011, there were 1,352 beneficiaries of the social service in-home assistance and care. The services within this package included organization of meals (supply of prepared meals in home, supply of groceries, assistance with preparation of meals), assistance with housework, assistance with personal hygiene and other daily needs. Ministry of Health and Social Welfare (2011), Monthly Statistical Social Welfare Report - November 2011 (data for October 2011). Retrieved on 05.02.2012 at http://www.mzss.hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/mjesecna_izvjesca_2011. Apart from this, there are two special programmes for implementation of generational solidarity in local communities (explained in Section 2.4.4).

[141] The Croatian Parliament, Explanation accompanying the Draft Act 746 – Social Welfare Act, retrieved on 21 April 2011 from: http://www.sabor.hr/Default.aspx?art=38514.

[142] Regulation on competence, procedure and conditions for generational solidarity services and residence generational solidarity services, Official Gazette of the Republic of Croatia, *Narodne novine* no. 124/11.

[143] Retrieved on 15.02.2012 at http://www.vlada.hr/hr/naslovnica/sjednice_i_odluke_vlade_rh/2012/8_sjednica_vlade_republike_hrvatske.

With the planned reduction of quasi-fiscal payments aimed at restoring the competitiveness of the Croatian economy, some local communities might lose part of their income. This could produce adverse effect on the organisation and co-financing of the provision of social services on their territory.

The aim of the new Foster Families Act is deinstitutionalisation and increase of the number of foster families, their professionalisation and specialisation for taking care of certain categories of beneficiares. Foster care is defined as a non-institutional type of care for children and adults out of their families. Types of foster care are defined according to beneficiaries (traditional, specialised, urgent and temporary) as well as the status of foster care (kinship, professional). At the time of the adoption of the act, there were 1,303 foster families for adults, who were taking care mainly for elderly and frail persons, persons with disability and mentally ill adults.[144] Foster care is provided only upon referral from the competent Social Welfare Centre. The impact of this regulation, particularly as regards the professionalisation and specialisation of the foster families, will have to be assessed in the upcoming period.

The role of the civil sector's associations in the long-term care arrangements is mostly concentrated on the promotion of active ageing, healthy living and overall social inclusion of disabled persons and elderly. There are various pensioner's associations organised at national, regional and local levels. For example, one of the oldest civil society organisations in Croatia is the National Pensioners' Convention of Croatia (*Cro. Matica umirovljenika Hrvatske*) with around 270,000 members, 300 associations and 800 branches and clubs at the local level. The association and its members, organise the purchase of winter foodstuffs, meat, fruits and vegetables, as well as heating fuel at preferential prices with payment by installments, while its volunteers visit the sick and infirm, and socialise in clubs, branches and associations.[145]

The scale of family care in Croatia is above the EU27 average. Around 17% of the respondents aged 35-49 report having to care for elderly relatives at least several times a week.[146] The age cohort 50-64 apparently bears the greatest load when it comes to taking care of elderly: 24% female respondents and 13% male respondents of that age group are involved in those activities, which places Croatia among the top three countries in Europe (after Italy and Estonia).[147]

2.4.2 Debates and political discourse

Under the existing Social Welfare System Development Strategy 2011-2016[148], which was adopted in April 2011 and whose future is uncertain due to the shift of government, combating poverty and social exclusion are key priorities. Among 16 measures for improvement of the social welfare system, there are several long-term care schemes aimed at social inclusion and raising the quality of life of elderly and dependent citizens, such as the introduction of the financial benefit for elderly without income and broadening of the generational solidarity services to new local communities.

---

[144] IUS-INFO, retrieved on 26.08.2011 at http://www.iusinfo.hr/DailyContent/Topical.aspx?id=10565.

[145] Retrieved on 06.03.2012 at http://www.muh.hr/index.php/about-us.

[146] EU27 average is 15% for women and 7% of men. Interestingly, there are no gender differences in that age cohort in Croatia, whereas in the age cohort 50-64 the gender gap is significant: 24% of women as opposed to 13% of men take care of elderly relatives. European Foundation for the Improvement of Living and Working Conditions (2010), Second European Quality of Life Survey: Family Life and Work, retrieved on 05.03.2012 at http://www.eurofound.europa.eu/pubdocs/2010/02/en/1/EF1002EN.pdf, p. 23.

[147] Loc.cit.

[148] Ministry of Health and Social Welfare (2011), Social Welfare System Development Strategy 2011-2016, retrieved on 12.12.2011 at http://www.mzss.hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/reforma_sustava_socijalne_skrbi.

In comparison with the EU Member States, Croatia has high ratio of elderly without pension or other income (more than 86,000 persons or 12.4% of the 64+ population or 2% of the total population). Since these persons are currently relying on several social welfare benefits for living, the proposed measure intends to facilitate access to the benefits and raise their quality of life, by introducing a single monetary compensation (a sort of a social pension). The implementation of this measure, estimated by 2013, will depend on fiscal capacities and the level of other benefits within the system. The new Government Programme for the mandate 2011-2015 departs from this solution and instead refers to the introduction of the so-called 'zero' pension pillar for payment of basic financial support financed from taxes, but the exact category of persons eligible for this support is not defined.

The Social Welfare Systems Development Strategy also recognises the fact that the Croatian society is ageing and that currently 16.5% of the population is over 65. This phenomenon is marked by significant regional disparities: Lika-Senj County leads with 22.7%, followed by Karlovac County (19.9%), Šibenik-Knin County (19.5%), Sisak-Moslavina County (18.1%) and Bjelovar-Bilogora County (17.3%). Many elderly live in rural and remote areas. Since 2004, two long-term care programmes (described in Section 2.4.4) are targeted at development of non-institutional services adapted to the needs of elderly in their homes and local communities. Both programmes ('In-home assistance for the elderly' and 'Daycare and in-home assistance for the elderly') have continued in 2011 from the previous reporting periods. However, by the time of submission of this ANR, the new Programme for the development of generational solidarity services for the elderly in the period 2012-2015 is still not adopted. The current activities are based on the programme adopted in 2007, for the period 2008-2011.[149] Presently, 91 generational solidarity programmes are operational (58 programmes of In-home assistance for the elderly and 33 programmes Daycare and in-home assistance for the elderly). There are 160 local communities which participate in the programmes from 19 counties, with 15,550 beneficiaries and 1,045 employed persons.[150] The services are provided free of charge. The competent ministry will renew the contracts with the existing contracting communities until the end of 2012 and after that time, if the funds for this purpose are made available in the State budget.

In the (new) Government Programme for the Mandate 2011-2015, the complete overhaul of the social welfare system is announced. The objectives and priorities have not changed though. Decentralisation and deinstitutionalisation will be continued in partnership and with the more active participation of civil society organisations and private sector. Functional and financial decentralisation of the system will be possible after the consolidation of the social welfare programmes, i.e. after 2012.

2.4.3 Impact of EU social policies on the national level

The Social Welfare System Development Strategy explicitly refers to the EU key principles in the field of social inclusion[151]: Subsidiarity, holistic approach, transparency and accountability, user-friendly services, effectiveness, solidarity and partnership, dignity and human rights, participation, personal development, permanent improvement and sustainability. These principles were also the basis for development of quality standards for social services, which were adopted in 2009 and amended in 2010.[152] With the entering into force of the new Social

[149] Official Gazette of the Republic of Croatia, *Narodne novine* no. 90/07.

[150] Data from October 2011, retrieved on 12.02.2012 at http://www.mobms.hr/ministarstvo/uprava-za-medugeneracijsku-solidarnost/izvaninstitucionalna-skrb-o-starijima/programi-medugeneracijske-solidarnosti.aspx.

[151] Council of the European Union 15/223/01.

[152] Ministry of Health and Social Welfare, Decision of 31.05.2010, class: 011-02/09-11/35, ref.no.:534-09-2/1-10-3 and Decision of 7.12.2009, class: 011-02/09-11/35, ref.no.: 534-09-2/1-09-1.

Welfare Act, the quality standards for social services became binding for all institutional and non-institutional social services. The quality standards include 15 general quality standards with pertaining quality indicators, applicable regardless of the type and nature of social services, their beneficiaries or organisation of the service provider. Additional special standards are designed for out-of-family services, separately for children and adult beneficiaries. The Guidelines for implementation accompany the Quality standards. Their purpose is to facilitate the implementing activities and promote awareness and independence of the service providers in assuring the required quality levels.

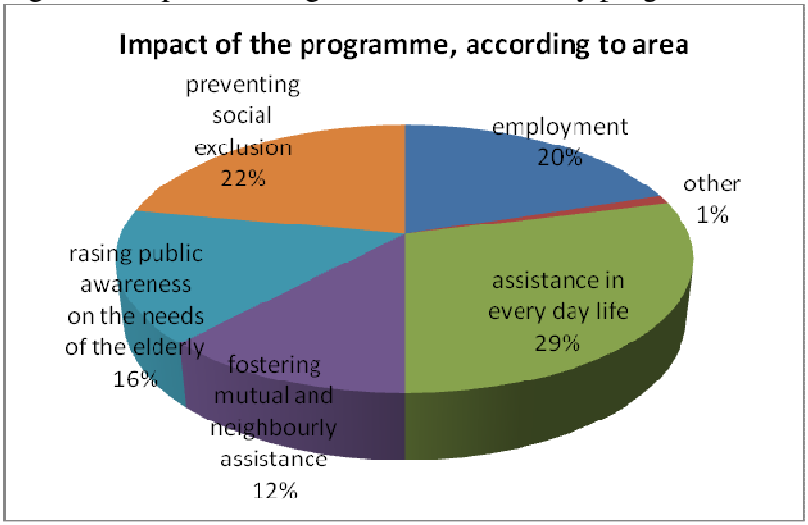
The Social Welfare System Development Strategy is drafted in accordance with various national and international strategic documents, notably Europe 2020 Strategy, the Joint Memorandum on Social Inclusion (JIM), the Economic Recovery Programme 2010, the New Strategy and Council of Europe Action Plan for Social Cohesion, etc.

The Strategy sets the initial theses for dealing with issues of ageing and long-term care, as well as poverty and long-term care. The accent is on keeping the beneficiaries in their familiar environments, i.e. creating the conditions for social integration in their communities. The expansion of social services network will be directed towards non-institutional services, especially in those areas where they are insufficiently developed. The trend of institutionalisation should be stopped in those counties in which a large number of persons are placed in homes. However, all these goals require further careful planning, especially as regards the causes for high demand of institutional services (see in Section 2.4.4).

2.4.4 Impact assessment

Under assumption that the new Programme for the development of generational solidarity services for elderly persons or a similar strategic document is going to be adopted, it will have to incorporate key findings of an independent evaluation of those programmes conducted in 2009. Regretfully, there were no regular annual evaluations of the programmes after that time, which would have been a better guarantee that its findings still apply in today's circumstances. According to the 2009 evaluation, the success of the implemented programmes was obvious at the level of personal satisfaction of beneficiaries and engagement of local resources. The benefits of these programmes are seen in the employment of local people, better networking of various services and lower cost of their provision. 99% of beneficiaries have recognised the programmes as useful and 97% of them believe that the programme has improved the quality of their lives.

Figure 7: Impact of the generational solidarity programmes, according to area



Source: Social Welfare System Development Strategy 2011-2016.

The conclusion of the 2009 evaluation was that the programmes are beneficial for development of local resources, introduction of European standards (such as right to participation, social inclusion, accessibility of services and choice of provider), promotion of partnership between private and public sector and flexible and user-oriented model of social services. Guided by the success of this model, the expansion of the programme to other local communities is planned under the Social Welfare System Development Strategy, with the objective of fostering of local employment, volunteering and raising awareness on the position and role of elderly in families and local communities and the importance of generational solidarity as continuous activities. Standardisation of the programme is foreseen by 2014.

Nevertheless, the pressure on institutional forms of care for elderly was not alleviated. In 2010, there were 196 homes for adults and the elderly (165 for the elderly and infirm, 29 homes for mentally ill adults and 2 institutions for alcohol and drug addicts). The most numerous age group of recipients was 80 and over (44.3% of all recipients), out of which 77.8% were women. The number of homes for the elderly and infirm in 2010 increased 3.1%.[153] The demand for long-term care institutional services exceeds the offer by at least two times. For example, in the County Primorsko-goranska, in 2010 there were 2,042 persons on the waiting list for placement in one of the four homes for the elderly and infirm run by the County. At the same time, only 822 persons were accommodated. In addition, around 600 persons were included in some of the non-institutional forms of care for the elderly. The waiting periods are measured in years.[154] In the city of Osijek, the average waiting time in the county home for the elderly is from at least 18 months for stationary to five or even ten years for apartment accommodation.[155] This means that, in cases of emergencies, when employed family members cannot afford to quit their jobs and take care of the frail, dependent or infirm family members (nor are they trained to do so), they cannot rely on limited and overcapacitated public institutions. Their only option is to resort to private and costly arrangements, which many cannot afford.

Apart from sporadic examples and evaluations conducted within the system itself, there are no academic debates and cross-comparable research of the design and impact of the Croatian long-term care measures. The quality of life of persons in the homes for the elderly and infirm in Zagreb was subject of analysis in a scientific paper under the same title in 2010.[156] The total quality of life, observed through subjective and objective scopes of the quality of life, proved to be average. The worst was the economic independence of elderly people. Over two thirds of respondents were financially dependent on third persons. A correlation between the aspects of the quality of life and the satisfaction with the services in the home was confirmed.

The accent on private provision of social services (including long-term care services) makes the monitoring of the quality of services even more important. It is recognised that the operation of services and benefits and their impact on the beneficiaries are not appropriately measured and evaluated in practice.[157] The new Social Welfare Act brings some improvements, with the possibility of appointing external experts for evaluation of private homes and publishing the results of findings on the website, as a guidance for potential beneficiaries.

---

[153] Croatian Bureau of Statistics (2011), Social Welfare Institutions for children, youth and adults 2010, First Release, 30.08.2011, retrieved on 15.01.2012 at http://dzs.hr/Hrv_Eng/publication/2011/08-04-02_01_2011.htm.

[154] Retrieved on 10.01.2012 at http://novilist.hr/Vijesti/Rijeka/Na-mjesto-u-starackim-domovima-u-PGZ-ceka-gotovo-tri-puta-vise-gradana-nego-ih-je-u-njima-smjesteno.

[155] Osijek danas, 13.09.2011, retrieved on 02.02.201 2 at http://www.osijek-danas.com/vijesti/1320-na-smjetaj-u-dom-za-starije-i-nemone-eka-se-i-10-godina.html.

[156] Lovreković, Marija; Leutar, Zdravka (2010), Kvaliteta života osoba u domovima za starije i nemoćne osobe u Zagrebu, Soc. ekol. Zagreb, Vol. 19, No. 1, p. 55-79.

[157] Social Welfare System Development Strategy 2011-2016.

2.4.5 Critical assessment of reforms, discussions and research carried out

Of all social protection issues, long-term care organisation in Croatia receives the least public attention. There is no integrated approach to LTC issues. The care for elderly and other persons in need of assistance for daily living is fragmented and perceived either as a health care or as a social welfare problem. Long-term care services have to be organised at local and regional levels. Therefore, to attain the OMC objective of ensuring adequate *access to long-term-care*, it is important that the planning of the coherent policy at national level follows a bottom-up approach, i.e. the inclusion of local communities in all stages of decision-making is indispensable. The risk that 'poorer' municipalities will not be able to provide such services to their citizens has to be offset by appropriate measures at regional and central level.

Changing social patterns diminish the traditional role of the family in providing care for the elderly. In some Croatian regions, the adaptation to the altered circumstances is sometimes difficult and the public perception of the importance of a coherent and sound LTC system is rather low. Political actors do not readily get involved in the debate, as it would imply their responsibility for creating and implementing LTC policies.

Although the quality standards for social services already exist,[158] guaranteeing the OMC objective of *quality long-term care* implies their effective in practice, as well as their regular revision and evaluation of relevance.

Financial sustainability of the system is currently not threatened, largely because of the limited scope of benefits and their amounts, as well as services provided within long-term arrangements. However, this could change in the long run, given the projections of rising public expenditures on long-term care under the "expansion of disability" scenario by approximately 1% of GDP in OECD and EU countries by 2050.[159] Prevalence of disability in age cohort 65+ of 28.2% is much higher than the average disability prevalence of total Croatian population of 12.1%.[160] The share of persons 65+ in the total number of disabled persons in 2011 was 37.7%, which is a drop in comparison with the data for 2010 (39.1%). In 2010, the share of social welfare beneficiaries in this age cohort was 36% or 73,749 persons. 69.7% of them lived with their family, 27.8% lived alone, whereas only 2% or 1,461 disabled persons 65+ resided in an institution. Approximately 20% of persons had inappropriate living conditions, while 67% of them were entitled to cash benefits – allowance for assistance and care.[161] The development of a coherent long-term care strategy requires a close scrutiny of the trends in old-age disability and the projections of their impact on public spending, which is currently absent in Croatia.

60% of respondents in the Eurobarometer Active Ageing Survey believe that the most useful thing the government could do to help people who take care for older family members is to provide some financial remuneration.[162] This is comparatively higher than the EU27 average (44%) and only two European countries value remuneration of carers higher than Croatia

[158] See section 2.4.3. of this ANR.

[159] These projections are very sensitive to policy changes. For more see: European Commission (2006), The impact of ageing on public expenditure: projections for the EU 25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050), Special Report No. 1/2006, p. 157; Lafortune, Gaetan; Balestat, Gaëlle (2007), Trends in Severe Disability Among Elderly People: Assessing the Evidence in 12 OECD Countries and the Future Implications, OECD Health Working Papers No. 26, retrieved on 10.03.2012 at http://dx.doi.org/10.1787/217072070078.

[160] Benjak, Tomislav (2012), Izvješće o osobama s invaliditetom u Republici Hrvatskoj, Hrvatski zavod za javno zdravstvo. According to EU25 projections (from 2004), approximately 17% of males and 23% of females aged 65+ were assumed to be disabled, whereas 20% of the elderly aged 65+ were dependent. European Commission (2006), op.cit.

[161] Benjak, Tomislav (2010), Osobe s invaliditetom u dobi 65 i više godine, Hrvatski zavod za javno zdravstvo.

[162] Eurobarometer, op.cit. (FN 39).

(Slovakia and Sweden). This could be result of the fact that there are currently no financial incentives for taking care of elderly relatives in Croatia. Having the right to work flexible hours or part time also ranks high on the list. A new approach to the modalities of financing, providing and regulating long-term care needs to be developed somewhere along the guidelines of public opinion and financial reality.

Policy recommendations

- Developing a coherent long-term care strategy, based on reliable, verifiable and cross-comparable data should be prioritised in the upcoming period.
- Provision and the quality of social services by private providers should be more closely and regularly monitored. This also implies the promotion of importance of monitoring and self-assessment of service providers to assure the quality of services.
- Greater visibility of the results of evaluations and inspections should be assured to enable potential future beneficiaries to choose the best provider for their needs.
- Development of non-institutional forms of care as a substitute for institutionalisation should not be pursued at the cost of leaving those who really need institutional care to themselves, i.e. their families. Building additional institutional capacities to cover the rising needs for stationary and palliative care does not mean the reversal of the objective of deinstitutionalisation. To assure better planning of long-term care services, a cross-comparable survey regarding the attitudes of the elderly beneficiaries of institutional and non-institutional types of care should be conducted. This would allow better targeting of the measures.
- The solution for social pension or basic financial support for elderly without income is still not in sight. Various concepts regarding the modality of its financing and payment are merely rhetorical and so far appear only as wishful thinking.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Financial stimulation of longer careers and later retirement is introduced in the pension system in 2010: a 0.15% increase of the amount of pension per month of later retirement, up to a maximum of five years, i.e. a maximum of 9% increase is possible. The reality is, however, that only 11.58% of pensioners have accumulated 40 or more years of pension service (which includes years of service and additional service years in accordance with the Pension Insurance Act). Changes in other fields of legislation are necessary to promote better employability and competitiveness of the elderly workers.[163] For example, the Compulsory Health Insurance Act prescribes that employees who have reached the required age and years of service for retirement are not entitled to compensation of salary from compulsory health insurance during sick leave (i.e. these expenses fall upon employer).[164] The Labour Act prescribes *ex lege* termination of employment relationship, when an employee turns 65 years of age, unless otherwise agreed with the employer. A review of this provision might contribute to a shift in perception on the longer stay in the world of work as an acceptable instrument for active ageing. Almost a third of respondents in Croatia believe that one starts to be regarded as "old" already in the age of 51-60.[165] Perception on the average age until respondents believe they will be capable of doing their jobs is at low 58.8 years (the lowest perception is among manual

[163] Vukorepa, op. cit., p. 124.
[164] See Croatia ANR 2011, p. 13-14.
[165] Eurobarometer, op.cit.

workers (56.6) and the highest among self-employed (64.1)), which is significantly under the formal retirement age. On the other hand, every fourth respondent claims that s/he would like to continue working after reaching the retirement age. Effective age management policies primarily imply the readiness of employers to keep older workers and benefit from their experience, even after they reach the retirement age.

The reality of employment of older workers is that every fifth person has witnessed age discrimination of older workers, while every tenth was the victim of such discrimination her/himself.

2.5.2 Participation in society

Only volunteer / unpaid work after completion of education (practical work) is considered as contributory period. Other forms of volunteering are not relevant within the meaning of social protection benefits.

There are frequent actions on promotion of volunteering as an activity which contributes to the general well-being and the quality of life in society. However, only 12% of the respondents (as opposed to the EU average of 26%) in Croatia actively participate or engage in volunteering work.[166] In the age group 55+, the participation falls to 9%. The greatest contribution of older people to society is traditionally seen in taking care of grand-children (87% of respondents).

Pensioners' associations and civil society organisations are the main promoters of active ageing and participation of elderly in society, through various meetings and events. As stated in section 2.4.4. of this ANR, one of the oldest and largest civil society organisations is the National Pensioners' Convention of Croatia with around 270,000 members, 300 associations and 800 branches and clubs at the local level.[167]

2.5.3 Healthy and autonomous living

Special health protection for elderly is organised at national and county levels. National Centres for Gerontology are established at the County Public Health Institutes, Public Health Institute of the City of Zagreb and the Croatian Public Health Institute. The Centre for Gerontology of the Public Health Institute of the City of Zagreb "Dr Andrija Štampar" is a national reference centre for gerontology. Its main task is to assure implementation of gerontological-public health activities in the City of Zagreb and counties. This task implies monitoring, evaluating and studying of health needs and functional capacities of elderly persons. The programmes of health measures and procedures in the health protection of elderly and preventive health measures at all levels of health protection (primary, secondary and tertiary) are elaborated with the aim of improving the health status of elderly and promoting active ageing. Gerontological centres are established in various locations across the country.

Home and non-institutional types of care are prioritised over institutional care, mostly through long-term care programmes of generational solidarity. There are no incentives, support or flexible job arrangements (e.g. part-time work or special vacation) for family members who take care of their elderly. There is a chronic lack of palliative care facilities and stationary care for infirm elderly. The Centre for Palliative Medicine, Medical Ethics and Communication Skills (CEPAMET) was established in 2010 as a semi-autonomous unit within the School of Medicine, University of Zagreb, in response to the insufficient and unsystematic institutional

[166] Eurobarometer, op.cit.

[167] There are 45,530 associations registered in the Registry of Associations of the Republic of Croatia (status on 05.03.2012). Some estimate that only one third of them is active. The search of the Registry shows that there are 1,619 registered associations which pursue some sort of social interests, out of which 552 are registered as pensioners associations.

approach to palliative medicine.[168] Its short term goal is to develop reasonable, scientifically based and cost-effective national strategy for palliative medicine, leading to specific initiatives for its implementation at the primary, secondary and tertiary health care level.

National prevention health programmes include preventive exams for insured persons over the age of 50 who have not visited their selected physician in the past two years, programmes for prevention of cardiovascular diseases and national breast cancer and colon cancer screenings. However, more effort is needed to increase the impact of the programmes. For example, only 10% of the invited participants for colon cancer screening submitted samples suitable for testing.[169] Furthermore, the first level of prevention, i.e. education of the population on healthy lifestyle and avoidance of health risks are also very important.

[168] Đorđević, Veljko *et al*. (2011), The founding of the Centre for Palliative Medicine, Medical Ethics and Communication Skills: A new step toward the development of patient-oriented medicine in Croatia, Croat. Med. J. 2011, 52: 87-8.

[169] Ministry of Health and Social Welfare (2011), Report on the Implementation of the Joint Inclusion Memorandum (JIM) of the Republic of Croatia in 2010, p. 56.

References

BABIĆ, ZDENKO (2008), Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj (The Role of Social Welfare in the Policy against Poverty in Croatia), *Privredna kretanja i ekonomska politika* 116/2008, Ekonomski institut, Zagreb, pp. 53 – 81.

BAĐUN, MARIJANA (2012), Izazov reformi javnog sustava mirovinskog osiguranja (Challenges to Public Pension System Reform), Aktualni osvrt 35, Institut za javne financije, retrieved on 06.02.2012 at http://www.ijf.hr/upload/files/file/osvrti/35.pdf.

BEJAKOVIĆ, PREDRAG; GOTOVAC, VIKTOR (2011), Aktivnosti na gospodarskom oporavku u Republici Hrvatskoj s naglaskom na tržište rada (Activities on Economic Recovery in Croatia, with Particular Attention to the Labour Market), in: Rev. soc.polit. 18 (2011) 3, Zagreb 2011, p. 331-355.

BENJAK, TOMISLAV (2012), Izvješće o osobama s invaliditetom u Republici Hrvatskoj (Report on persons with disability in the Republic of Croatia), Hrvatski zavod za javno zdravstvo.

BENJAK, TOMISLAV (2010), Osobe s invaliditetom u dobi 65 i više godina (Persons with disability in the age cohort 65+), Hrvatski zavod za javno zdravstvo.

CROATIAN BUREAU OF STATISTICS (2011), Social Welfare Institutions for children, youth and adults 2010, First Release, 30.08.2011, retrieved on 15.01.2012 at http://dzs.hr/Hrv_Eng/publication/2011/08-04-02_01_2011.htm.

CROATIAN BUREAU OF STATISTICS (2011), Results of Households Budget Survey 2009, retrieved on 10.01.2012 at http://www.dzs.hr/Hrv_Eng/publication/2010/SI-1426.pdf.

CROATIAN BUREAU OF STATISTICS (2011), The Household Budget Survey, First Release, 28.10.2011, retrieved on 10.02.2012 at http://www.dzs.hr/.

CROATIAN BUREAU OF STATISTICS (2011), Women and Men in Croatia 2011, Zagreb.

CROATIAN BUREAU OF STATISTICS (2011), Poverty Indicators 2010 (released 30.11.2011), retrieved on 10.02.2012 at http://www.dzs.hr/Hrv_Eng/publication/2011/14-01-02_01_2011.htm.

CROATIAN EMPLOYMENT SERVICE (2012), Registered unemployment and employment in January 2012, retrieved on 14.02.2012 at http://www.hzz.hr/docslike/PR_Nezaposlenost-Zaposljavanje_01_2012.pdf.

CROATIAN EMPLOYMENT SERVICE (2012), Registered unemployed and employment in December 2012, Zagreb, retrieved on 01.02.2012 at: http://www.hzz.hr/docslike/Nezaposlenost_Analiza_Prosinac_2011.pdf.

CROATIAN EMPLOYMENT SERVICE (2011), Statistical Yearbook 2010, retrieved on 20.01.2012 at http://www.hzz.hr/DocSlike/HZZ_Godisnjak_2010.pdf.

CROATIAN INSTITUTE OF HEALTH INSURANCE (2011), Izvješće o poslovanju zdravstvenih ustanova za 2010. godinu (Report on operation of medical institutions in 2010).

CROATIAN INSTITUTE OF HEALTH INSURANCE (2011), Izvješće o poslovanju Hrvatskog zavoda za zdravstveno osiguranje za 2010. godinu (Annual Report 2010).

CROATIAN INSTITUTE OF PUBLIC HEALTH (2011), Rad bolnica i bolnički pobol u Hrvatskoj 2010 (Hospitals and hospitalizations in 2010), retrieved on 10.02.2012 at http://www.hzjz.hr/publikacije/bolnicki_2010.pdf.

CROATIAN PENSION INSURANCE INSTITUTE (2012), Statističke informacije 4/2012 (Statistical Data), retrieved on 10.02.2012 at http://www.mirovinsko.hr/UserDocsImages/publikacije/statisticke_informacije/2011/4/Statisticke_informacijeHZMOa_4_2011_veljaca2012.pdf.

CROATIAN PUBLIC HEALTH INSTITUTE (2011), Croatian Health Service Yearbook 2010.

ĐORĐEVIĆ, VELJKO *et al*. (2011), The founding of the Centre for Palliative Medicine, Medical Ethics and Communication Skills: A new step toward the development of patient-oriented medicine in Croatia, Croat. Med. J. 2011, 52: 87-8.

EUROBAROMETER Survey on Active Ageing, Results for Croatia, retrieved on 18.01.2012 at http://ec.europa.eu/public_opinion/archives/ebs/ebs_378_fact_hr_en.pdf.

EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT (2011), Life in Transition Survey II, retrieved on 05.02.2012 at http://www.ebrd.com/pages/research/publications/special/transitionII.shtml.

EUROPEAN COMMISSION (2011), Communication from the Commission 'Annual Growth Survey' COM (2011)815 final.

EUROPEAN COMMISSION (2006), The impact of ageing on public expenditure: projections for the EU 25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050), Special Report No. 1/2006.

EUROPEAN FOUNDATION FOR THE IMPROVEMENT OF LIVING AND WORKING CONDITIONS (EUROFOUND) (2010), Second European Quality of Life Survey: Family Life and Work, retrieved on 05.03.2012 at http://www.eurofound.europa.eu/pubdocs/2010/02/en/1/EF1002EN.pdf.

GOVERNMENT OF THE REPUBLIC OF CROATIA (2011), The Government Programme for the mandate 2011-2015, retrieved on 24.12.2011 at http://www.vlada.hr/hr/preuzimanja/program_vlade_2011_2015.

GOVERNMENT OF THE REPUBLIC OF CROATIA (2012), Prijedlog mjera i smjernice za izradu proračuna za 2012. Godinu (Measures and Guidelines for the State Budget 2012 Drafting), retrieved on 27.01.2012 at http://www.vlada.hr/hr/aktualne_teme_i_projekti/aktualne_teme/proracun_2012.

INSTITUTE OF ECONOMICS, ZAGREB (2012), Croatian Economic Outlook Quarterly No. 49/January 2012.

INTERNATIONAL MONETARY FUND (2011), The Challenge of Public Pension Reform in Advanced and Emerging Economies, retrieved on 06.02.2012 at http://www.imf.org/external/np/pp/eng/2011/122811.pdf.

LAFORTUNE, GAETAN; BALESTAT, GAËLLE (2007), Trends in Severe Disability Among Elderly People: Assessing the Evidence in 12 OECD Countries and the Future Implications, OECD Health Working Papers No. 26, retrieved on 10.03.2012 at http://dx.doi.org/10.1787/217072070078.

LOVREKOVIĆ, MARIJA; LEUTAR, ZDRAVKA (2010), Kvaliteta života osoba u domovima za starije i nemoćne osobe u Zagrebu, Soc. ekol. Zagreb, Vol. 19, No. 1, p. 55-79.

MIHALJEK, DUBRAVKO (2012), Financing Health in Times of Crisis, presentation at the round table organised by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.

MINISTRY OF HEALTH AND SOCIAL WELFARE (2011), Report on the Implementation of the Joint Inclusion Memorandum (JIM) of the Republic of Croatia in 2010.

MINISTRY OF HEALTH AND SOCIAL WELFARE (2011), Monthly Statistical Social Welfare Report - November 2011 (data for October 2011), retrieved on 05.02.2012 at http://www.mzss.hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/mjesecna_izvjesca_2011.

MINISTRY OF HEALTH AND SOCIAL WELFARE (2011), Social Welfare System Development Strategy 2011-2016, retrieved on 12 December 2011 at http://www.mzss.hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/reforma_sustava_socijalne_skrbi.

NESTIĆ, DANIJEL (ed.) (2011) Izazovi i mogućnosti za ostvarenje primjerenih starosnih mirovina u Hrvatskoj (Challenges and Possibilities for the Realisation of Adequate Old-Age Pensions in Croatia), Ekonomski institut Zagreb, retrieved on 16.12.2011 at http://www.eizg.hr/Download.ashx?FileID=7d4509d2-866d-47b7-8214-a2cbf38ff8b9.

OSTOJIĆ, RAJKO (2012), Health Care System Condition, presentation at the round table organised by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.

OTT, KATARINA (2012) Smisao i svrha smjernica makroekonomske politike (The Meaning Of Macroeconomic Policy Guidelines), Aktualni osvrt br. 34, 01.02.2012, Institute of Public Finances, Zagreb, retrieved on 05.02.2012 at http://www.ijf.hr/upload/files/file/osvrti /34.pdf.

POLOŠKI VOKIĆ, NINA; GRGURIĆ, LANA, Upravljanje zaposlenicima starije životne dobi – model djelotvornog upravljanja u hrvatskim organizacijama (Age Management – The Development of an Effective Model for Croatian Organisations), in: Rev. soc. polit. 18 (2011) 2, Zagreb 2011, p. 149-174.

PULJIZ, VLADO (2011), Kriza, reforme i perspektive mirovinskih sustava u europskim zemljama i Hrvatskoj (Pension Systems in European Countries and Croatia: Crisis, Reforms and Perspectives), in: Privredna kretanja i ekonomska politika 129 (2011), Zagreb, p. 27-64.

RADIN, DAGMAR; DŽAKULA, ALEKSANDAR; BENKOVIĆ, VANESA (2011), Health Care Issues in Croatian Elections 2005-2009: Series of Public Opinion Surveys, Croat. Med. J. (2011) 52, 585-92.

SMOLIĆ, ŠIME (2011), Nekima Švicarska nekima gorka pilula, Banka, retrieved on 16.12.2011 at http://www.bankamagazine.hr/Naslovnica/IzBanke/tabid/393/View/Details/ItemID/74463/ttl/Nekima-Svicarska-nekima-gorka-pilula/Default.aspx

ŠKREBLIN KIRBIŠ, IVONA; TOMIĆ, IVA; VEHOVEC, MAJA (2011) Mirovinska pismenost i štednja za treću životnu dob (Pension Literacy and Savings for Third Age) (scientific paper) Rev. soc. polit. 18 (2), Zagreb, p.127-148.

ŠTIMAC, DUBRAVKO (2011), Obvezni mirovinski fondovi – prvih 10 godina, in: Zbornik radova Analiza mirovinskog sustava, Banka magazin i Institut za javne financije, Zagreb, retrieved on 11.01.2012 at http://www.bankamagazine.hr/LinkClick.aspx?fileticket=W6kzsdxFPSY%3d&tabid=43.

ŠUĆUR, ZORAN (2011), Siromaštvo i dohodovne nejednakosti u Hrvatskoj: 2001.-2009. (Poverty and Income Inequalities in Croatia: 2001-2009), in: Rev. soc.polit. 18 (2011) 2, p. 245-256.

ŠVALJEK, SANDRA (2012), Last Health Reform: Search for Additional Means or Something Else?, presentation at the round table organised by the Magazine Banka and the Institute of Economics Zagreb on 06.02.2012 in Zagreb. Retrieved on 10.02.2012 at http://www.bankamagazine.hr/Projekti/Analizazdravstvenogsustava.aspx.

UMFO - Udruženje društava za upravljanje mirovinskim fondovima i mirovinskih osiguravajućih društava (2011), Mirovinska reforma u Republici Hrvatskoj: dosadašnji učinci, aktualno stanje i prijedlozi za budućnost (Pension Reform in Croatia: Impact, Current Status and Suggestions for the Future), retrieved on 01.02.2012 at http://www.azfond.hr/doc/Mirovinska%20reforma.pdf.

UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC) (2011), Corruption in the Western Balkans: Bribery as Experienced by Population, retrieved on 10.02.2012 at http://www.unodc.org/documents/data-and-analysis/statistics/corruption/Western_balkans_corruption_report_2011_web.pdf.

URBAN, IVICA (2011) Stvarni dohodak umirovljenika (Real Income of Pensioners) in: Zbornik radova Analiza mirovinskog sustava, Banka magazin i Institut za javne financije, Zagreb, retrieved on 11.01.2012 at http://www.bankamagazine.hr/LinkClick.aspx?fileticket=W6kzsdxFPSY%3d&tabid=43

VUKOREPA, IVANA (2011) Kapitalno financirani mirovinski sustavi kao čimbenici socijalne sigurnosti (Capitally Financed Pension Systems as Factors of Social Security) (PhD Thesis), Zagreb.

WORLD BANK (2011) Croatia: Policy Options for Further Pension System Reform, retrieved on 10.01.2012 at http://siteresources.worldbank.org/INTCROATIA /Resources/Croatia_Policy_Notes-Pension.pdf.

WORLD BANK (2011) EU 10+1 Regular Economic Report, Croatia Supplement, retrieved on 10.01.2012 at

http://siteresources.worldbank.org/ECAEXT/Resources/258598-1256755672295/6517642 1321421981603/EU10RER_CroatiaDec2011.pdf.

WORLD HEALTH ORGANISATION (2011), European Health for All Database (HFA-DB), retrieved at http://data.euro.who.int/hfadb/.

WORLD HEALTH ORGANISATION (2010), Country Cooperation Strategy at a glance, retrieved on 12.12.2011 at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_hrv_en.pdf.

ZUBER, MARIJA (2011) Kontroverze važećeg sustava oporezivanja mirovina (Controversies of the Pension Taxation), retrieved on 24 April 2011 at: http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BAHOVEC, Vlasta; DUMIČIĆ, Ksenija; ŽALAC, Ana, Trendovi u koncentraciji imovine mirovinskih fondova u Republici Hrvatskoj, in: Zbornik Pravnog Fakulteta u Zagrebu 9 (2011) 2, Zagreb 2011, p. 53-75.

"*Trends in Concentration of Pension Funds Assets in Croatia*"

The aim of this paper is to explore the tendency in movement of the concentration of the total pension fund assets in Croatia and to predict further movement in concentration. Data on total pension funds assets were analysed in the period from year 2002 to 2010 and following concentration indices were calculated: concentration ratio, Herfindahl-Hirschman index, Theil entropy, Gini coefficient, standardised Gini coefficient of concentration and Lorenz curve. Based on the result of the graphic and numerical analysis, a slight increasing trend of concentration with a tendency to slow down and approaching a fixed level of concentration was noticed. For the purposes of short-term forecasting of concentration the precision of simple exponential smoothing model was observed and evaluated. Based on calculation of the mean squared error the mentioned model is superior to the asymptotic trend models tested.

[R3] BALOKOVIĆ, Snježana, Prijevremeno umirovljenje u Republici Hrvatskoj, in: Revija za socijalnu politiku 18/1 (2011), Zagreb 2011, p. 61-76.

"*Early Retirement in the Republic of Croatia*"

The subject of paper is the review of early retirement system in the Republic of Croatia before pension reform, which began at the beginning of 1999, and a comparison with the system after the introduction of reforms. Early retirement system is a part of pension insurance system in almost every European country, and was particularly popular in South- Eastern European countries, due to rather generous schemes. These systems are different, regarding conditions for entitlements to the early retirement, as well as regarding the amount of pensions. South-Eastern European countries have prescribed rather generous conditions for early retirement before the commencement of pension reforms, and at the same time the amounts of the early retirement pensions were relatively high. Those amounts were only slightly below the amount of old-age pension, although the right to an anticipatory pension could be acquired in average up to five years before the old-age pension. Therefore, the early retirement was very interesting for a large number of potential beneficiaries, so this kind of pension was not treated as an exemption, but as a rule for retirement as soon as people were entitled to it. Economic crisis is a kind of trigger for obtaining the right to early retirement, because sometimes it is the only way out of a

new situation where job seeking could be rather unsuccessful due to bad conditions caused by the economic crisis. However, after the introduction of reforms, the rules for early retirement are more or less similar in all European countries.

[R4] BEJAKOVIĆ, Predrag; GOTOVAC, Viktor, Aktivnosti na gospodarskom oporavku u Republici Hrvatskoj s naglaskom na tržište rada, in: Rev. soc. polit. 18 (2011) 3, Zagreb 2011, p. 331-355.

"*Activities on Economic Recovery in Croatia, with Particular Attention to the Labour Market*"

The text is dedicated to the description of activities on economic recovery in Croatia, with particular attention to the labour market. Most important trends and determinants of employment and unemployment in the last five years are analysed with the goal to get an insight into their impact and possible improvement. While decision on economic recovery and development prepared by the Government of Croatia is mentioned, the authors do not attempt to provide its final evaluation because this is a topic for some new survey. The paper consists of four sections. In section 1 the economic situation in Croatia in the period from 2005 to 2007 is explained as the one characterised by a significant annual growth of gross domestic product, while in 2008 economic activity started decelerating as a consequence of the global economic crisis. Section 2 explains the impact of the crisis on the labour market. While unemployment decreased in pre-crisis period, since 2008 there has been a constant decrease in the number of the employed and an increase in the number of the unemployed. Croatia has a relatively low activity and employment rate, particularly for women, youth and older persons. Policy responses to the crisis are the topic of the section 3, which focuses on economic and social policies, as well as labour market policies. The final section deals with the issues of further economic development of Croatia, primarily with priorities in employment policy.

[R2] DUJMOVIĆ, Filip, Politika reforme mirovinskih sustava: komparativna analiza Hrvatske, Slovenije i Srbije, in: Društvena istraživanja 111 (2011) 20/1, p. 113-135.

"*Pension System Reform Policies: Comparative Analysis of Croatia, Slovenia and Serbia*"

The main subject in this paper is the transformation of the pension systems in Croatia, Slovenia and Serbia, witch followed after Yugoslavia broke up. The process of establishing the new pension system was made on the foundations of the PAYG system, which was effective in the whole territory of former Yugoslavia. The outcomes of these reforms were different despite the influence of the World Bank advice (multi pillar system, transferring the financial base from government to individual, diversification of financial investment). In the paper, the emphasis is on the demographic and financial sustainability with many statistical data. It is concluded that Croatia is trying to resolve the pension system problems by introducing the mandatory funded pillar scheme, which must not be abandoned because of the transitional cost over the years, which would then have been futile. Slovenia introduced only the voluntary funded pillar, but because of bad demography in the future, the first pillar might become a large burden. Serbia also introduced only the voluntary funded pillar, but the reason for abandoning the idea of introducing the mandatory funded pillar was the inability to fund the transitional costs. Nevertheless, this option is not yet completely abandoned. The success of the pension reform will be shown in the future when the workers who participated in the new systems most of their working lives become retired.

[R2] GUARDIANCICH, Igor, The Survival and Return of Institutions: Examples from Pension Reforms in Central, Eastern and South-Eastern Europe, in: West European Politics 34 (2011) 5, p. 976-996.

Opening a new phase in historical institutionalism, Wolfgang Streeck and Kathleen Thelen show how a rigid dichotomy between incremental adaptation and radical transformation fails to

capture important transformative processes common to advanced political economies. While their research focuses on gradual but radical transformation, the two authors leave open the interpretation of what constitutes abrupt, but only limited change. This article integrates their framework, defines what they call survival and return, and, within this genus, indicates two analytically distinct species: replication, where the old logic survives due to the redundancy of the new institutional arrangement; and reaction, where structural reforms generate demand for the old incentive structures, which are ultimately reintroduced. To elucidate the concepts, recent Croatian, Hungarian and Polish pension reforms are compared and their institutional instability analysed.

[R1; R2; R3] NESTIĆ, Danijel (ed.), Izazovi i mogućnosti za ostvarenje primjerenih starosnih mirovina u Hrvatskoj, Ekonomski institut Zagreb, 2011 retrieved on 16.12.2011 at http://www.eizg.hr/Download.ashx?FileID=7d4509d2-866d-47b7-8214-a2cbf38ff8b.

"*Challenges and Possibilities for the Realisation of Adequate Old-Age Pensions in Croatia*"

The Croatian Pension System has been faced with numerous problems and challenges during the last two decades. Notwithstanding the adjustments conducted towards the end of 1990s and the structural reforms initiated in the beginning of 2000s, many ambiguities regarding the direction and manner of the future pension system development have remained. Not only have the implemented reforms failed to solve the problem of low pensions, but they also resulted in new distributions within the retired population, so that ideas of abandonment of initiated reforms and return to the old system have appeared. Therefore pension system reform remains a key priority of the Croatian government. The study 'Challenges and possibilities for the realisation of adequate old-age pension in Croatia', which emerged in 2011 as the result of the research conducted by a team of experts from the Economic Institute in Zagreb and the Faculty of Law in Zagreb, represents a significant contribution to the debates about future reforms of the pension system. The study was prepared within the project bearing the same title that was financially aided by the Adris Foundation. The study consists of three parts. The first part comprises three chapters that consider the problems and challenges of the pension system in Croatia, assess current adequacy of pensions and projections for the next forty years, and offer proposals for the measures for further pension system reform with the aim of ensuring adequate and sustainable pensions on the basis of the research results. The second part of the study analyses in more detail two topics connected with the reform proposals, and these are the control of the second pillar yields and the spread of financial and pension-related literacy in Croatia.

[R4] POLOŠKI VOKIĆ, Nina; GRGURIĆ, Lana, Upravljanje zaposlenicima starije životne dobi – model djelotvornog upravljanja u hrvatskim organizacijama, in: Rev. soc. polit. 18 (2011) 2, Zagreb 2011, p. 149-174.

"*Age Management – The Development of an Effective Model for Croatian Organisations*"

Ageing population is one of the demographic processes typical for contemporary society. Both nations and organisations should therefore recognise the significance of age management, in other words, of taking care and empowering older employees to add value. The paper deals with age management concept both on theoretical and empirical level. In the theoretical part, age management is explored through definition, stimuli, participants and activities of age management, as well as explication of early retirement factors. Empirical part of the paper presents research results about the potential early retirement factors of 182 respondents. At the end of the paper, based on both theoretical and empirical findings, the model for effective age management in Croatian organisations is proposed.

[R1; R2] PULJIZ, Vlado, Kriza, reforme i perspektive mirovinskih sustava u europskim zemljama i Hrvatskoj, in: Privredna kretanja i ekonomska politika 129 (2011), Zagreb, p. 27-64.

"*Pension Systems in European Countries and Croatia: Crisis, Reforms and Perspectives*"

This paper deals with pension systems in Europe and in Croatia. First it provides an overview of the beginnings of pension systems, their expansion after World War II and their crisis that started in the mid 1970s. Today pension systems are facing enormous challenges, such as demographic regression, financial pressures to enable competitiveness on the globalised market, transformation of economy, particularly of the labor market, and strong resistance of citizens to pension reforms. The paper discusses the various measures undertaken by European countries to adjust pension systems to the new social and economic environment. The paper also describes the Croatian pension system and its transformations in the past decades, pointing out the current issues facing the Croatian pension system and its probable directions of change. It is concluded that long-term sustainability of the pension system depends primarily on economic growth and a diversified financing structure.

[R5] ŠKREBLIN KIRBIŠ, Ivona; VEHOVEC, Maja, TOMIĆ, Iva, Mirovinska pismenost i štednja za treću životnu dob, in: Rev. soc. polit. 18 (2011) 2, Zagreb 2011, p. 127-148.

"*Pension Literacy and Savings for the Third-Age*"

Individual responsibility and private savings for retirement are becoming increasingly important for the adequate financing of living standards in the third age. However, in order to invest in private forms of retirement savings, working age individuals should be sufficiently pension literate or informed. In this paper researchers examine the differences between pension literate and illiterate participants, as well as the link between pension (il)literacy and various types of private savings for the third age on a representative sample of active population in Croatia. Pension illiterate group makes more than a half of the active working population in Croatia. When compared to pension literate active population, they are statistically significantly different according to certain demographic characteristics, attitudes and beliefs, as well as behaviors and intentions towards savings for the old age. One of the most important findings is that the pension literacy is an important predictor of non-traditional types of savings, indicating that the pension literacy may represent a significant boost to private savings for retirement. In addition to pension literacy, a significant predictor of all types of private savings is the attitude towards a specific type of savings. This implies that raising measured elements of attitude, such as trust towards the specific type of savings for the third age and its perceived appropriateness, is another possible way to encourage private savings.

[R5] VEHOVEC, Maja, Financijska i mirovinska pismenost: međunarodna iskustva i prijedlozi za Hrvatsku, in: Privredna kretanja i ekonomska politika 129 (2011), Zagreb 2011, p. 65-85.

"*Financial and Pension Literacy: International Experiences and Proposals for Croatia*"

This paper analyses the importance of financial and pension literacy and provides an overview of international experiences as well as recommendations for key activities to be undertaken in Croatia. Financial literacy programmes are linked to financial education projects, and both types of activities were launched in developed countries less than a decade ago. Targeted pension literacy campaigns are based on demographic changes, i.e., a growing proportion of older population, and on the need to ensure adequate income in the third age. Retirement systems are becoming more and more complex, with public retirement systems that can no longer guarantee abundant pensions, while private or combined systems increasingly require an understanding of how financial markets work. The paper proposes a framework for the application of a financial and pension literacy model in Croatia.

[H] Health

[H7] BARIŠIN, Andreja; BENJAK, Tomislav; VULETIĆ, Gorka, Health-related quality of life of women with disabilities in relation to their employment status, in: Croatian Medical Journal 52 (2011), Zagreb 2011, p. 550-6.

The aim of this article is to compare the health-related quality of life of unemployed and employed women with disabilities and establish factors affecting their life satisfaction. The study included 318 women with disabilities, 160 of whom were employed and 158 unemployed, paired according to age and region of residence. The health-related quality of life was assessed by The World Health Organisation Quality of Life questionnaire, and social demographics and factors affecting life satisfaction were collected by a general questionnaire. The factors affecting life satisfaction were defined according to respondents' statements. Unemployed women with disabilities had a lower mean score (±standard deviation) on all health-related QoL domains: psychological health (14.52 ± 2.80 vs 15.94 ± 2.55), social relationships (15.12 ± 3.08 vs 16.06 ± 2.69), environment (12.80 ± 2.78 vs 13.87 ± 2.49), as well as on a separate item of self-assessed health (3.33 ± 1.16 vs 3.56 ± 0.92) than their employed counterparts ($P < 0.01$). This disparity was not found only in the domain of physical health. The largest positive impact on life satisfaction in both groups was family. As disabled women are a particularly vulnerable population group, stressing the importance of employment and family as factors affecting their quality of life may help equalising opportunities and upgrading the quality of life of all – particularly unemployed women with disabilities.

[H1] BREDENKAMP, Caryn; MENDOLA, Mariapia; GRAGNOLATI, Michele, Catastrophic and Impoverishing Effects of Health Expenditure: New Evidence from the Western Balkans, in: Health Policy & Planning 26 (2011) 4, p. 349-356.

This paper investigates the effect of health-related expenditure on household welfare in Albania, Bosnia and Herzegovina, Montenegro, Serbia and Kosovo, all of which have undertaken major health sector reform. Two methodologies are used: (i) the incidence and intensity of 'catastrophic' health care expenditure, and (ii) the effect of out-of-pocket payments on poverty headcount and poverty gap measures. Data are drawn from the most recent Living Standards and Measurement Surveys, 2000–05. While our analyses are not without their limitations, and the lack of comparability across instruments precludes a direct comparison across countries, there is no doubt that health expenditure contributes substantially to the impoverishment of households—increasing the incidence of poverty and pushing poor households into deeper poverty—in each country. Both the catastrophic and the impoverishing effects of health expenditures are particularly severe in Albania and Kosovo. Transportation expenditure accounts for a large share of total health expenditures, especially in Albania and Serbia. Informal payments are substantial in all countries, and are particularly high in Albania. As countries in the sub-region continue the process of health system reform, an important policy question should be how to protect vulnerable groups from the catastrophic and impoverishing effects of health care expenditure.

[H2] MESARIĆ, Jasna et al., Alat za ocjenu rada u cilju poboljšanja kvalitete u bolnicama: prva iskustva u provođenju programa PATH u hrvatskim bolnicama, in: Liječnički vjesnik 133 (2011) 7/8, Zagreb 2011, p. 231-298.

"*Performance Assessment Tool for Quality Improvement in Hospitals (PATH): First Experiences in Croatia*"

PATH (Performance Assessment Tool for Quality Improvement in Hospitals), a project of the World Health Organisation (WHO) for Europe offers hospitals a comprehensive and standardised tool (a set of indicators) to evaluate their own performance and development of measures for quality improvement. PATH Programme was launched in Croatia in 2008, and it

was conducted in 2009 in hospitals that have voluntarily decided to be involved. Here we present the results of the first phase of pilot experience of establishing the programme, based on data collected in 22 Croatian hospitals. Analysis of the first results indicated the existence of marked differences among the hospitals that have taken the example of the percentage of cesarean sections ranging from 1.1% to 21.4%. The mortality rate of myocardial infarction ranged from 1.9 to 21.4%, while the mortality of stroke ranged from 12.5 to 45.5%. The highest percentage of needle-stick injuries reported for physicians was 16.2% of entire hospital staff in one year, 6.1% for nurses and 4.6% for the supportive staff. The result suggests the existence of many problems and limitations in data collection at hospital level, limitations in their analysis and creates recommendations for quality improvements, which must be taken into account when hospitals are compared on the national or international level.

[H6] VOGLER, Sabine et al., Comparing Pharmaceutical Pricing and Reimbursement Policies in Croatia to the European Union Member States, in: Croatian Medical Journal 52/2 (2011), Zagreb 2011, p. 183-97.

Aim: To perform a comparative analysis of the pharmaceutical pricing and reimbursement systems in Croatia and the 27 European Union (EU) Member States. Methods: Knowledge about the pharmaceutical systems in Croatia and the 27 EU Member States was acquired by literature review and primary research with stakeholders. Results: Pharmaceutical prices are controlled at all levels in Croatia, which is also the case in 21 EU Member States. Like many EU countries, Croatia also applies external price referencing, i.e. compares prices with other countries. While the wholesale remuneration by a statutorily regulated linear mark-up is applied in Croatia and in several EU countries, the pharmacy compensation for dispensing reimbursable medicines in the form of a flat rate service fee in Croatia is rare among EU countries, which usually apply a linear or regressive pharmacy mark-up scheme. Like in most EU countries, the Croatian Social Insurance reimburses specific medicines at 100%, whereas patients are charged co-payments for other reimbursable medicines. Criteria for reimbursement include the medicine's importance from the public health perspective, its therapeutic value, and relative effectiveness. In Croatia and in many EU Member States, reimbursement is based on a reference price system. Conclusion: The Croatian pharmaceutical system is similar to those in the EU Member States. Key policies, like external price referencing and reference price systems, which have increasingly been introduced in EU countries are also applied in Croatia and serve the same purpose: to ensure access to medicines while containing public pharmaceutical expenditure.

[L] Long-term care

[L] LEUTLOFF-GRANDITS, Caroline, Kinship, Community and Care: Rural-Urban Contrasts in Croatia, in: Ethnologie Française 2011 (42) 1, p. 65-78.

Based on the study of an urban and a rural field site in Croatia, the article analyses the meaning and roles of relatives in post-socialist Croatia. It argues that despite various commonalities, like the proximity of the close family and extensive family orientation, two rather distinct kinship rationalities are at place. In urban Travno, spatial proximity of the close family fosters intra-familial support, which enables families to react on the new flexibilities of the working life as well as supports women to establish themselves on the labour market. In the rural field site, in which the labour market situation is more constrained, family proximity and strong family values lead to the retreat of women into the domains of the household and of (subsistence) agriculture. Those who do not comply with it opt for outmigration. The growing importance of life stage festivals, in which the dense, overlapping networks of relatives, neighbours, friends and godparents, are recreated and values re-established, stabilises village communities and their distinct kinship rationality.

[L] RUSAC, Silvia; ČIZMIN, Ana, Nasilje nad starijim osobama u ustanovama, in: Med. Jad. 2011 (41) 1-2, p. 51-58.

"*Institutional Abuse of the Elderly*"

The aim of this work is to approach the abuse issue of older persons in health and social care institutions. Abuse of the elderly can be intentional or non-intentional, and it can, therefore, cause damage to older people from the formal nursing attendant/professional, as well as the noninsurance of basic needs and protection of the elderly from injuries. This includes psychological, physical, financial and sexual abuse and negligence. This work shows the forms of abuse, risk factors that can bring to abusive professional behaviour, a view of past researches on this issue, prevention measures that can be taken and which some countries have taken in order to suppress abuse of the elderly in such institutions. Since the topic of institutional abuse of the elderly has not yet become a research issue in the Republic of Croatia, one needs to refer to international data and cognition which emphasise the importance of the perception of abuse of the elderly by professionals, the need for elderly protection and the need to engage in this matter.

[L] TOMEK-ROKSANDIĆ, Spomenka; ŠOSTAR, Zvonimir; FORTUNA, Višnja, Četiri stupnja gerijatrijske zdravstvene njege sa sestrinskom dokumentacijom i postupnikom opće / obiteljske medicine u domu za starije osobe, 2011, Zagreb, retrieved from: www.stampar.hr/lgs.axd?t=16&id=2945.

"*Four Levels of Geriatric Health Care with Documentation for Nurses and Procedure Guide for General/Family Medicine Practitioners in the Elderly Care Homes*"

This book was made at the Dr. Andrija Štampar Institute of Public Health – Centre of Gerontology (Referral Centre of the Ministry of Health for Gerontology). The authors are experts in geriatric health care and specific primary elderly health protection in institutional and non-institutional gerontological health care. The book was written in association with the Croatian Chamber of Nurses. The purpose of the book is to assist all those involved in providing health services to the Croatian elderly population with the implementation of the Programme of health measures and procedures for elderly. All materials and practical advice are based on monitoring and studying health and health care needs of the elderly.

4 List of Important Institutions

Ekonomski institut Zagreb – The Institute of Economics, Zagreb

Contact person: Sandra Švaljek, Head of the Institute

Address: Trg J. F. Kennedyja 7, P.O. box 149, 10000 Zagreb, Croatia, Webpage: http://www.eizg.hr/

The Institute of Economics, Zagreb is a public scientific institute that conducts scientific and development research in the field of economics. It is particularly dedicated to conducting empirical research in order to improve the understanding of Croatia's economy and identify policy measures that could spur its growth and development.

The Institute was founded in 1939, and owes its longevity to perseverance in the objectivity and quality of scientific research. Since then, the Institute has encouraged freedom of thought and expression. It is independent of any political structure or interest group, and unburdened by ruling ideologies. The impartiality in the scientific work is also derived from the institute's mixed financing – approx. 60% of the institute's income is paid from the state budget, while the rest is earned on the market and comes from donations.

Serial Publications:

- *EIZ Working Papers*
- *Economic trends and economic policy*
- *Croatian Economic Survey*
- *Croatian Economic Outlook Quarterly*

Hrvatski zavod za javno zdravstvo – The Croatian Institute for Public Health

Contact person: Prim. mr. sc. Željko Baklaić, Head of the Institute

Address: Rockefellerova 7, 10000 Zagreb, Croatia

Webpage: http://www.hzjz.hr/index.htm

The Croatian National Institute for Public Health, established in 1923, is a central institution of public health in Croatia. Its task is to monitor and evaluate all factors influencing the health of the Croatian population, including contagious diseases, non-contagious massive chronic and acute illnesses, safe and healthy nutrition, public water supply and waste disposal, as well as information regarding laboratory diagnostics and analytics and various data regarding the organisation and operation of the health care system in its entirety. It publishes various reports and the Croatian Health Service Yearbook.

Institut za javne financije - The Institute of Public Finance

Contact person: Dr Katarina Ott, Head of the Institute

Address: Smičiklasova 21, 10000 Zagreb, Croatia

Webpage: http://www.ijf.hr

The Institute of Public Finance, founded in 1970, is a public institution dealing with research into primarily economic topics important for economic growth and development, transition to the market economy and meeting the requirements for European integration.

Under the general aegis of public sector economics, topics such as transparency, accountability and participation, the tax system, costs of taxation, progressiveness of taxation, fiscal federalism, the pensions system and the welfare system, public debt, the unofficial economy, state aid, foreign direct investment, the financing of science and higher education, and the relations between the executive branch and the legislature in the budgetary process are subjected to ongoing investigation.

Ministarstvo rada i mirovinskog sustava – Ministry of Labour and Pension System

Contact person: Mirando Mrsić, Minister

Address: Ulica grada Vukovara 78, 10 000 Zagreb, Croatia
Webpage: http://www.mingorp.hr (under construction)

The Ministry of Labour and Pension System is reorganised under the Act on Organisation and Competences of Ministries and Other Central State Authorities (Official Gazette Narodne novine no. 150/11) and conducts active policy of employment and pension system. The Ministry conducts administrative and other work concerning: work relations; labour market and employment; relationships with unions and employers' associations; labour law status of Croatian citizens employed in foreign countries and work concerning their return and employment in the county; labour law status of aliens employed in the Republic of Croatia; occupational safety; international cooperation in labour and employment sector and pension and disability insurance system and policy.

Ministarstvo zdravlja – Ministry of Health
Contact person: Rajko Ostojić, Minister
Address: Ksaver 200a, 10 000 Zagreb, Croatia
Webpage: http://www.mzss.hr/ (under construction)

The Ministry of Health does administrative and other tasks related to: protecting the population from infectious and non-infectious diseases, ionising and non-ionising radiation; health validity of foods and objects in an everyday use; use of health care potentials; construction and investments in health care; setting up of health care institutions and private practice; organisation of state and professional exams for health care personnel and their specialist training; recognition of primarius title; naming of health care institutions: referral centre, clinic, hospital clinic and hospital clinic centre; administrative supervision of functioning of Croatian Health Insurance Institute, Croatian Red Cross and chambers; health care inspection of functioning of health care institutions, health care employees and private practice; drugs registrations, pharmaceutical inspection of manufacturing and traffic of drugs and health products; sanitary inspection of manufacturing, traffic, use and disposition of poisons; manufacturing, traffic and use of narcotics;sanitary inspection of persons and activities, buildings, offices, spaces, facilities and equipment which can have any harmful effects on human health; sanitary inspection of international traffic at the state borders.

Ministarstvo socijalne politike i mladih Republike Hrvatske – Ministry of Social Policy and Youth
Contact person: Milanka Opačić, Minister
Address: Trg hrvatskih velikana 6, 10 000 Zagreb, Croatia
Webpage: http://www.mspm.hr/ (under construction)

The Ministry is reorganised under the Act on Organisation and Competences of Ministries and Other Central State Authorities (Official Gazette Narodne novine no. 150/11), when social welfare component dissolved from the Ministry of Health. The field of competence of the new ministry includes fostering of the rights of persons with disability and elderly and raising their life quality, as well as, promotion of non-institutional care for persons with disability and elderly.

Pravni fakultet Sveučilišta u Zagrebu, Studijski centar socijalnog rada – Faculty of Law, University of Zagreb, Social Work Study Centre
Contact person: Prof. Dr. sc. Siniša Zrinšćak
Address: Nazorova 51, 10000 Zagreb, Croatia
Webpage: http://www.pravo.hr

The Social Work Study Centre is a place of dissemination of knowledge and research activities in the fields of social policy. The departments organised within the Centre include the Social

Policy Department, Department of Special Fields of Social Labour, Department of Social Gerontology, Department of Theory and Methodology.
Publishing activities within the Centre include the following publications:

- *The Journal of Social Policy – includes a variety of social policy issues, papers on pension, health, family, housing, educational policies, work related issues, unemployment, poverty, social assistance and other social issues and current processes in the society. Along with original papers, the journal also includes translated papers, various documents, statistical data and reviews.*
- *Yearbook of Social Work Study Centre deals with various subjects, including theoretical and methodological findings and education in the field of social work. Papers from all applied fields of social work and associated fields are also published.*

Pravni fakultet Sveučilišta u Rijeci – Faculty of Law, University of Rijeka
Contact person: Prof. Dr. sc. Nada Bodiroga – Vukobrat
Address: Hahlić 6, 51000 Rijeka, Croatia
Webpage: http://www.pravri.hr/

International conferences in the field of social protection and insurance are organised each year under the auspices of the Faculty of Law Rijeka. The Organisation Committee is chaired by Professor Nada Bodiroga-Vukobrat. The last international conference was held in October 2011, under the title "Invisible Minorities". In 2010, the international conference "Regulatory Agencies" was held, in 2009, the international conference "Open Methods of Coordination", in 2008, the international conference "Social Rights as Fundamental Rights" took place, and in 2007 "Corporate Social Responsibility". In 2006, the topic was cross-border and regional cooperation, while in 2005 the international conference was entitled "Social Security and Competition – European Requirements and National Solutions".
The works of eminent scholars and participants in the conferences are published in the collection of papers which follows each conference.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en